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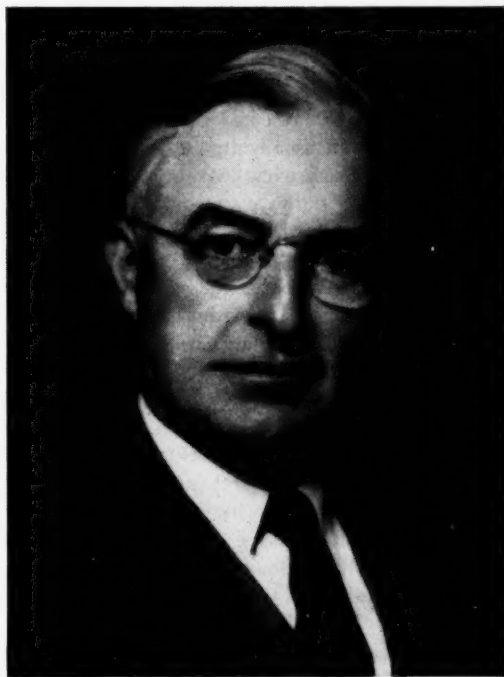
February, 1954

NUMBER 2

EDITORIAL

C. R. EDWARDS, M.D.*

Rotation in office is a proper expression of our democratic way of government in all of its forms, and when one's term of office is ended, the recent incumbent usually in complacency rejoins the ranks and is happy to be relieved of many duties. Modesty, therefore, would dictate against the writing of these lines but duty says otherwise.



C. R. EDWARDS

The Medical and Chirurgical Faculty was founded 155 years ago. It was founded by an ardent few who felt the need of an interchange of ideas, also the exchange of the few

* Immediate Past Chairman of the Council.

publications that were available, and for infrequent meetings where professional fellowship might prove beneficial. They, also in the early years, wanted and worked prodigiously to establish a library.

Looking back upon those early days from our vantage point, it all seems very simple. Through the years however, slowly, continuous progress has been noted.

Organization of the Medical and Chirurgical Faculty was made effective under our Constitution by planning for a Council and a House of Delegates recognizing all parts of the State.

In subsequent years simplicity seemed to disappear and a more complex, professional life was upon us. The individual "Family Doctor" slowly merged into one in a great community of doctors and organizations. Health Departments, State, County and City, were now organized to extend the benefits of the practice of medicine, to expand certain health laws, and to be of great benefit to both the practitioner and patient.

Blue Cross and Blue Shield and Hospitalization Insurance of various types came into being, and have proved of great value. But all of these organizations call for physicians' membership on their various Board of Directors, and have placed a burden on the officers of the Medical and Chirurgical Faculty.

It can be readily appreciated that the amount of work required of the Headquarters' office has trebled in the past 5 or 6 years. We as a Faculty have been exceptionally fortunate in having Mr. Walter N. Kirkman as our Director. His long experience as a valuable officer in our State government, and his constant contact with our profession, our hospitals and other welfare organizations, fitted him very particularly for the work he has so effectively done for us. He, as well as all of us have been ably assisted by the devoted personnel always to be found at 1211 Cathedral Street.

While the House of Delegates can usually transact its business at the meetings each year—annual and semi-annual, it has proven necessary for the Council to have meetings about every two months, and there is always so much to be done, that for two years we have held our meetings at 4:30 p.m. usually extending until 9 p.m. with a short recess for dinner.

These facts are recorded simply to emphasize the importance of regarding the operations of the Medical and Chirurgical Society as a big business.

Mr. Kirkman has informed the Council that it will be necessary to find a replacement for him in the not too distant future. This will prove a very difficult task, but we must continue to develop our Faculty and in no way permit it to withdraw from any of its responsibilities.

Our Legislative Committee always alert may, before this issue of the Journal is read, find itself busy at Annapolis fighting legislations prepared by various cults who, though totally unprepared, desire to "practice medicine."

The Medical Practice Act has endured many assaults. So far it still stands supreme. We want it as it is, but if we wish to maintain the freedom of the practice of medicine, we must do it ourselves. All kinds of cults attack us, and there have been attempted incursions by certain misguided government agencies or individuals.

In nine years on the Council, and almost three as its Chairman, the writer has learned that the responsibilities of the Medical and Chirurgical Faculty are so numerous, so complex, so continuous, so demanding and so important, that an efficient staff constantly on duty is required.

The devotion to duty and the attendance of the members of the Council has been marvelous to observe, but we have only begun. We have entirely outgrown our facilities, and there could be no better time than now to revive our expansion program and provide ample room for our Headquarters and Library as well as a new auditorium.

FIFTY YEARS—IN RETROSPECT

THE LAST OF THE MEDICAL TRILOGY

The Heritage of Medicine—1933; The Past, Present and Future—1950; Wither Goest Thou?—1953

J. ALBERT CHATARD, M.D.

INTRODUCTION

1903–1953—What a span of years during which so much has happened. Much has been accomplished, and yet so little learned. By learning, I do not mean knowledge, for that has steadily increased beyond all expected attainment; but rather have we learned our lesson well?—have we profited by the past?—have its results been used properly?—or have they been wasted on the efforts to obtain a goal—not yet reached and not to be reached until we retrace our steps and take up each result, year by year. And, as in a “jig-saw puzzle,” put each separate piece into its proper position.

The arraignment of any resulting reward for our struggle can only be reached by looking back, as through a mirror, on the good or bad things that were there. Have we used the inherited good in the right way?—or have we been choked by the bad things on the roadside?—and not developed along the way that leads to truth and the way of life that means so much to future generations?

THE MARCH OF THE DECADES

With some worry about the benefits resulting, I have been asked to add a few words by way of reminiscence.

As you know, historically the first decade of this century developed and crystallized much of the knowledge and research of the late “ninety’s.” Diseases were better known and their treatment and prevention became greatly improved.

The second decade advanced even further, and a great store of knowledge emanated from what was learned during World War I and immediately after.

The third decade was a period of assimilation

during which the knowledge gained was used to increasing advantage.

The fourth decade witnessed new methods and new knowledge of the care of patients. It made a fitting prelude for the very excellent medical care rendered during World War II.

The last decade may be called the “antibiotic years,” giving us wonderful help in the alleviation of many diseases. The future looks bright for many wonderful achievements. However, such developments have put an added burden on the present race by lengthening the span of life to an expectancy of about sixty-eight years. A new important study has now arisen called “Geriatrics.”

THE TRANSITION PERIOD

In this brief outline of fifty years we see how much has been accomplished, and how remarkable has been our past. I have tried to bring out the salient points in our present relation to what went before, and how much we owe to those ancestors of ours who practiced what they preached.

Life was simpler then and competition less keen. As I hold the mirror, I see a disquieting picture of the modern practice of medicine. Possibly I am unusually alarmed, however, I have the impression that modern medicine has become materialistic,—and that results are measured in terms of an interesting case! Where, or where, has gone the feeling and relationship of one human to the other—your patient? Success is measured differently these days!—Will it last? Has a Frankenstein risen among us?

OUR PROGRESS

Medicine, as a vocation, has always been on a plane above most other modes of life and

existence. We owe a lot to the past and must work harder than ever to pass this ideal to the future.

To the young man contemplating the study of medicine—I would like to warn him that he must have above all else a "vocation" and not just enter medicine as a method of living. The country doctor has certainly been the best example of "true love" for his profession. His motivation is a desire to benefit his fellow man. The recompense may be little or nothing financially, but to his glory and that of the profession he is the shining example of what can be done.

THE CRITICAL PERIOD

In years gone by when professional matters went wrong, they were settled in two ways: (1) ignoring the past, and (2) trying to patch up the future, forgetting that such a thing happened, and thereby accepting a loss with dignity. This way seemed old fashioned, but it worked successfully. Coming to more modern times, the sad loss of personal contact and interest and friendly relation to our patients, as our best friends, brought out an era (modern age) in which the doctor lost the old close friendship with his patients and became an intellectual automaton. He knows all about disease and treatment. However, without the faculty of applying it, and without the ability of reassurance and solicitation such knowledge

becomes of little avail. In the early days it was often noted that Mr. So and So said he would rather be sick under Dr. A than get well under the care of Dr. B. A smile and optimism, a reassuring hand shake or pat on the back may prove to be extremely helpful.

Let us hope that the new generation of doctors will acquire, with their greater modern knowledge, a little flavoring of the old methods that did so much to endear the "family physician" to the family, from the youngster to the aged. All hail to the personalities that can adjust themselves to the different ages—it is not easy but can be acquired by trying harder to adjust to the patient's knowledge, his apprehension and his trustfulness.

OUR REWARD

These words may be altruistic but they come from the heart. Far be it for everyone to be perfect—such a race would become monotonous and would leave little inspiration for progress. Differences of nature, mind and soul make up the world about us.

Our highest goal to reach is the one of "charity to all." In our thoughts, words, and deeds, we have an opportunity to develop and reveal this side of our nature. The reward is exceedingly great. With it have a degree of humility. This enables one to practice in such a manner as to reap the satisfying joy and pleasure of doing something for others.

HOUSE COMMITTEE MAY RESUME HEARINGS ON INSURANCE

The AMA Washington Letter, No. 51

Although plans aren't definite, the House Interstate and Foreign Commerce Committee hopes to schedule hearings on health insurance for early January. The committee devoted two days to the subject in October, and adjourned with the understanding that it would complete its study after the first of the year. The contemplated hearings would look into all phases of pre-pay plans, including catastrophic illness insurance, and would hear selected representatives from the American Medical Association, cooperative health plans, labor, Blue Cross and Blue Shield, Health Information Foundation, the Committee for Economic Security and others.

STUDY OF PREMATURES

Dr. George H. Yeager

Editor

The Maryland State Medical Journal

1211 Cathedral Street

Baltimore 1, Maryland

Dear Dr. Yeager:

This open letter to the physicians of Maryland is a progress report on the Study of Prematures which is being carried out by the Division of Maternal and Child Health of the Johns Hopkins University with the endorsement of the Medical and Chirurgical Faculty and other groups.

A field investigation of retrolental fibroplasia is being conducted as a special part of this Study and is the primary subject of this letter. This new disease has become the chief cause of admissions to schools for the blind and this part of the Study has the particular endorsement of our Medical Advisory Committee, of the Ophthalmological Section of the Medical Society, of the Committee on Maternal and Child Welfare of the Medical and Chirurgical Faculty, of the Maryland Society for the Prevention of Blindness and of other groups.

Since the incidence of retrolental fibroplasia is highest in the smallest prematures, all babies of less than $3\frac{1}{2}$ pounds (1500 grams) birth weight are being visited by Dr. Rothmund, a member of our staff. In each instance, the consent of the family physician is secured through a letter about this part of the Study or through a telephone call or both.

The purpose of Dr. Rothmund's visit is to determine the presence or absence of any gross visual defects. Questions about general development are interspersed with those concerning vision, and simple tests such as the ability of the baby to see a small pellet are used as aids in diagnosis. Every effort is made not to arouse concern in the parents about the child's vision.

In addition to these visits to babies under $3\frac{1}{2}$ pounds, a brief questionnaire is being mailed to mothers of babies with a birth weight between $3\frac{1}{2}$ and $4\frac{1}{2}$ pounds. Whenever the mother's answers suggest any visual difficulty, the child is visited after prior contact with the family physician.

Ultimately, all children with eye defects suggestive of retrolental fibroplasia should be referred to an ophthalmologist for final diagnosis. Our consultants have advised that these examinations should all be done by four or five ophthalmologists in order to give uniformity of diagnosis and especially to obtain agreement upon the stage or degree of disease. A classification adopted by the National Committee on Retrolental Fibroplasia and published in the October 1953 American Journal of Ophthalmology is being used. This may mean that we will ask to have a repeat consultation on some babies who have already visited an ophthalmologist.

It now appears that about 35 to 40 babies throughout the state show enough evidence of visual difficulty to warrant consultation. We are aware that some of these infants have only minimal evidence of visual defect; others already have a diagnosis of retrolental fibroplasia but information about the stage of disease based on the above classification is not available; all of them meet our criteria for an ophthalmological consultation. In each case, we will call the family physician to obtain his approval and to arrange details. Each consultant will send his report to the family physician with a copy to the Study office. Pathology will not be discussed but parents of these children will be told that a report will be mailed to their family physician. There will be no charge for these consultations.

As of this writing, the following ophthalmologists have agreed to act as consultants: Dr. Angus MacLean, Dr. Arnall Patz, Dr. Frederic Reese and Dr. Roy Scholz of Maryland and Dr. Frank Costenbader of Washington, D. C.

I would now turn to a brief comment on the Study as a whole. It will be remembered that the Study has two aims: The first of these is to evaluate hospital care of prematures in terms of survival. As a result of excellent cooperation of physicians and hospitals throughout the state, data about hospital care and survival of nearly 5,000 prematures born in 1952 have been collected and are being analyzed. A report on this material should be ready in the next six months.

The second main purpose is to determine how many of those prematures who do survive develop normally and in what ways the other survivors are handicapped. This part of the Study requires a long term follow-up over ten or twelve years. The first phase of this long time investigation is a Gesell type of developmental examination done on about 500 prematures and 500 full term control babies in Baltimore City. These examinations are being done when the baby is about 40 weeks of age and are now nearly completed. Plans are being developed for the future follow-up of these 500 prematures and their full term controls and will be the subject of a later report.

We would again like to thank the physicians of Maryland for their cooperation and to say that questions or suggestions are welcome.

Sincerely yours,
Paul Harper
Paul Harper, M.D.

November 24, 1953

DEFENSE DEPARTMENT'S SCHOLARSHIP LEGISLATION IS ABOUT READY

The AMA Washington Letter—No. 47

Defense Department's draft legislation for medical and other federal scholarships is receiving a final checking over before presentation to the Budget Bureau for approval. Budget Bureau approval is necessary if the plan is to be presented as an administration bill, but regardless of the bureau's action, the proposal could be offered by any member of House or Senate. Essential provisions of the plan:

1. Any medical, dental, nursing, or veterinary student accepting a scholarship would be obligated for one year of federal service for each scholarship year.
2. Payment would be made directly to the schools for tuition and other incidentals and to the student to cover living expenses during the school year.
3. Scholarships, limited to four years, would not be offered to pre-medical students or others preparing for professional courses.
4. Deans would make recommendations, but final selection would be by the Defense Department.

According to a department spokesman, there are two objectives: First, to meet armed forces needs after expiration of the doctor draft in 1955, if the regular draft obligation does not produce enough officers. Second, to interest enough young officers in regular military careers to maintain the regular corps at the necessary level. Currently regular medical officers make up only about 25% of the medical corps total; it is hoped to reverse this ratio.

Scientific Papers

THE CLINICAL VALUE OF ARTERIOGRAPHY¹

E. CONVERSE PEIRCE, II, M.D.²

Many clinicians have little familiarity with the techniques of contrast visualization of the arteries of the body and suppose that they can get along quite well without them. They have heard that the procedures may be dangerous, producing thrombosis, hemorrhages or brain damage and have not felt that they would like to subject their patients to these hazards. Others have seen or made a few arteriograms and have been overimpressed by the beauty and clarity of the demonstrated arteries to such an extent that they have made examinations without much relation to the needs of the patient. Somewhere between these two extreme points of view lies the real clinical value of arteriography.

Recent advances in surgical treatment of aneurysms, arteriovenous fistulas, and arterial blocks have made imperative accurate preoperative delineation of the vessels in the region of the contemplated surgical procedure. In addition arteriography has been most helpful in the differential diagnosis of aneurysm and tumor in many areas. It has been a helpful adjunct in the evaluation of a few types of congenital cardiovascular disease and it shows promise of continued usefulness in the evaluation of renal and adrenal disease. In time I believe the various arteriographic methods will be very widely used. This paper will deal primarily

with the usefulness of arteriography without particular reference to its several methods.

Peripheral arteriography was first reported in 1923. It is a relatively simple procedure to perform but unless surgery is contemplated seldom gives information necessary to the care of the patient that cannot be obtained more easily by simple physical examination. Arterial blocks, aneurysms, and arteriovenous fistulas can be outlined, frequently providing information of great value to the vascular surgeon. Occasionally an arteriogram may make it possible to differentiate an atypical thrombophlebitis that mimics an arterial occlusion because of its profound vasospasm from an actual occlusion. It may also be possible to prove the presence of an occlusion when classical signs including pain and anesthesia are lacking.

Cerebral arteriography is a procedure of undoubted great clinical merit. It was reported by Egas Moniz in 1927 and the Nobel prize was awarded for this work in 1949. Cerebral arteriography is clearly indicated in cases of subarachnoid hemorrhage, and in many cases with intracranial space occupying lesions gives information on localization and type of lesion that is not otherwise obtainable. One possible advantage over air study is that it is not necessary to be prepared for immediate craniotomy in cases of tumor with increased pressure. Since the introduction of a percutaneous method and the use of dilute diodrast the procedure has been used very widely. There are clear cut dangers of brain damage, however, precluding the indiscriminate use of this examination.

Translumbar and catheter methods are valu-

¹ Presented at the Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, Wednesday afternoon, April 29, 1953, Osler Hall, Baltimore, Maryland.

² U.S. Public Health Service Hospital, Baltimore, and National Heart Institute, Bethesda. U.S. Department of Health, Education, and Welfare. (Present address, Acuff Clinic, Knoxville, Tenn.)

TABLE 1
Clinical Value of Abdominal Arteriography

Diagnosis and anatomical evaluation of vascular lesions
Aneurysms
Arteriovenous fistulas
Arterial occlusions
Pathological diagnosis of many renal lesions including:
Hydronephrosis
Tumors
Inflammation with destruction or perirenal abscess
Cysts
Vascular abnormalities
Malformations
Evaluation of parenchymal damage in kidney
Areas of decreased opacification in nephrogram
Decrease in calibre of arteries
Localization of functional adrenal masses
Pheochromocytoma
Adrenal cortical tumors
Adrenal hyperplasia
Assistance in evaluation of obscure masses
Location and size may be shown by aortic, renal or iliac displacement, etc.
Tumors may be identified by characteristic pooling of contrast medium or increased regional vascularity
If an organ such as kidney or spleen is involved this may be disclosed by its typical vascular pattern
Various organs may be excluded by having normal vascular patterns
Vascular obstruction by infiltrating tumor may be shown

TABLE 2
Clinical Value of Thoracic Arteriography

Differential diagnosis of neoplasm and aneurysm
Diagnosis and evaluation of acquired vascular lesions
Aneurysms
Dissecting aneurysms
Arteriovenous fistulas
Aortic regurgitation
Syphilitic aortitis
Diagnosis and evaluation of congenital vascular lesions, especially when obscure
Coarctation
Patent ductus arteriosus
Aortic septal defect
Arch anomalies
Aortic and subaortic stenosis

able for examination of the abdominal aorta. The areas in which the procedures may be useful are indicated in Table 1. In general arteriography is of greatest value in precise evaluation of lesions of the aorta and iliac arteries prior to

surgery and in this group of conditions there is no substitute for this examination. Recently adequate arterial visualization has rendered practical resection and grafting for aneurysms. Occlusions can be more adequately evaluated and treated. Occasionally valuable information pointing to the correct diagnosis and proper surgical approach has been obtained in the case of obscure abdominal and retroperitoneal masses. Adrenal tumors can sometimes be localized to the proper side greatly simplifying the surgical approach. Precise evaluation of renal lesions may be possible. Cysts have been distinguished from neoplasms, clinically significant aberrant vessels have been visualized, and parenchyma damaged by tuberculosis has been distinguished from adjacent normal tissue simplifying segmental resections. The use of arteriography in renal disease has been rather highly developed in a few centers although this is not its most remunerative field. These procedures have relatively little danger although a few complications are reported.

Angiocardiology and various direct catheter methods are suitable for evaluation of the thoracic aorta and its branches. Other methods have quite limited usefulness. The diagnostic value of the various procedures is indicated in Table 2. The differentiation of aneurysm from neoplasm or other extra aortic mass can be done only by arteriography in some cases. Adequate preoperative contrast studies permit necessary preparation to deal definitively with many aneurysms and at the worst may save the patient an unnecessary thoracotomy. Thoracic arteriography is very useful in the evaluation of a few complicated forms of congenital heart disease, especially patent ductus arteriosus with atypical murmurs or coarctation of the aorta presenting unusual clinical features such as absence of rib notching where the narrowed segment may be in an atypical location or long enough to require a graft. Thoracic arteriography by catheter entails the hazard of cerebral damage from the contrast material and consequently should not be undertaken unless the information

is really needed. Because of the diversity of thoracic problems those performing contrast studies in this area should be entirely familiar with the various available techniques and their hazards.

SUMMARY

Arteriography may be conveniently divided into cerebral, peripheral, abdominal and thoracic methods each differing considerably from the

others. Arteriography is the only definitive method for the study of many vascular lesions including occlusions, aneurysms, and arteriovenous fistulas. It is useful for studying tumors in many areas and is a desirable adjunct in the evaluation of certain cases of congenital cardiovascular disease. The various methods should be more widely used than is presently the practice.

PANEL DISCUSSION: BLOOD DYSCRASIAS¹

Introduction

CYRUS C. STURGIS, M.D., *Moderator*²

One of the greatest problems facing the medical profession at present is keeping abreast with current developments in medicine. I estimated from the examination of the Current List of Medical Literature the other day, that there are between 110 and 120 thousand medical articles written each year. A single person, of course, cannot read all those articles and even if we could read them it would be exceedingly difficult to evaluate many, particularly if they were not in some field in which we were working. Therefore, I think Panels

such as this are worthwhile because you can have a statement by someone who is an authority in the field as to what his opinion is in regard to certain important aspects of Hematology. Any one of the four men who are with me on the Panel could spend the entire evening speaking in the particular aspect of Hematology in which he is interested, but time, of course, does not permit this.

As a result, we have picked out five different topics, each one assigned to a member of the Panel, and we will start by giving fifteen minute talks on these special subjects. This will take 75 minutes. Then there will be a period of Questions and Answers and I hope you will send up some questions and we shall try to answer them.

So without further comment then, I wish to call on our first speaker, Dr. Norwood, who is to discuss Drugs and Chemicals Responsible for Blood Disorders, and we will hold him strictly to fifteen minutes

¹ Presented before the Baltimore City Medical Society on Friday, January 16, 1953, at the Medical and Chirurgical Faculty Building, 1211 Cathedral Street, Baltimore 1, Maryland.

² Professor of Internal Medicine, University of Michigan School of Medicine, Ann Arbor, Michigan.

DRUGS AND CHEMICALS RESPONSIBLE FOR BLOOD DISORDERS

VERNON H. NORWOOD, M.D.

Dr. Sturgis, and members of the Baltimore City Medical Society.

In considering the subject of "Drugs and Chemicals Responsible for Blood Disorders," we find it difficult to attempt a comprehensive list of significant materials, since chemical and pharmaceutical research constantly offer new

products which may be a potential hazard, demonstrated only by extended use. However, we can consider some of the more commonly encountered substances which are recognized as significant at the present time. These substances may be chemicals to which the body is exposed incidental to daily life or occupation or

they may be products used for medicinal purposes. The drugs may be deliberately used for a known and constant effect upon the blood system or the hematological effects may be incidental to other actions or of only occasional occurrence. These latter compounds, which only occasionally cause trouble, are of greater significance since the unpredictable results may have grave consequences and frequently appear with little warning in the unsuspecting patient.

The effects upon the blood may involve the peripherally circulating blood, or more frequently the bone marrow as the site of blood formation and may affect principally the red cell elements or else the myeloid and platelet elements, or may affect all three together or in variable combinations.

Industrial exposure subjects the worker to many substances which are of a toxic nature, attacking the blood system frequently alone or in combination with action on other organs. Of such substances, Benzene (Benzol) has one of the most striking effects on the blood system. When used in pure form as a solvent for many commercial processes or occurring as a contaminant of other hydrocarbons, it produces a variable picture which always manifests itself ultimately as a profound anemia in which all elements of the blood are concerned. As with most substances encountered under these circumstances, a variable picture will be seen with emphasis upon destruction of white cells in one case and of red cells in another and invariably ending, in the most aggravated forms, as an extremely intractable aplastic anemia. In respect to this substance, as in the case of many drugs with which we are concerned, individual susceptibility appears to be important since experience has shown that the occasional individual will succumb to exposures which have no apparent effect on colleagues working under the same conditions.

Lead is a product encountered under many circumstances which besides affecting other

organ systems, often produces a significant anemia which appears to result from the effect of lead upon the peripherally circulating blood, without damage to the bone marrow. The result is, that in lead poisoning, evidence of regeneration is strong and an aplastic marrow is not likely to be encountered.

Anilinism, a comprehensive term to describe the effects of exposure to a large group of compounds of the same chemical family, including Aniline oil itself and the aromatic nitro and amino compounds of Aniline, are notorious for their effect on the blood, producing methemoglobinemia which results in a striking and characteristic cyanosis and in chronic cases, producing a considerable degree of anemia.

The nitrotoluenes and nitrophenols, some of which have been used in medicine, may produce either anemia or agranulocytosis.

Among drugs administered as therapy in blood diseases, which may affect the blood unfavorably, we may once again mention Benzol for its historic interest. Because it does destroy blood cells, Benzol has been used in the treatment of leukemia, producing a very effective reduction in total count. This, however, is an obsolete therapy at the present time, since the same effect may be accomplished by other means at a less risk.

Phenylhydrazine, used in the treatment of polycythemia, will drastically reduce the red cells by increasing their fragility and aiding in their removal from the circulation without affecting the bone marrow or significantly affecting the white blood cells. Used carelessly, it can produce a profound and dangerous degree of anemia.

Urethane used in recent years for treatment of leukemia, again produces its effects by a toxic action on the bone marrow, resulting in a reduction of the total white cell count and again must be used with caution to avoid excessive destruction.

Folic acid antagonists such as Aminopterin, used for treating malignant disease, must be

used with care since profound degrees of bone marrow depression with anemia and agranulocytosis result from their uncontrolled administration.

Nitrogen mustard, useful for malignancies and lymphomatous diseases, is interesting in that it may affect all blood elements, but has a particularly selective effect on the lymphocytes of the circulating blood.

Drugs used for other effects upon the body but producing occasional unfavorable action on the blood, next come under consideration. The first drug which should be considered, because of its historic significance, is the analgesic compound, Aminopyrine, which was ultimately incriminated as the cause of fatal cases of agranulocytosis, which began to appear in increasing numbers in the late 1920's. This new syndrome of complete disappearance of granulocytic cells from the circulating blood without effect on the hemoglobin or red cell count, and marked clinically by fever and the appearance of gangrenous ulceration of the oral mucous membranes, was first shown by Madison and Squier, to be related to the ingestion of Aminopyrine. This drug in either its pure form or administered in proprietary combinations and forms under the name of Pyramidon, Amytal Compound, Allonal, Cibalgin, Neonol, Peralga, and others, was used in tremendous quantities and a very significant point was quickly realized, namely that this drug was not toxic per se, but that an individual susceptibility played a part in the production of its dangerous effect. The same individual idiosyncrasy shows up in most of the drugs which have to be considered as potentially toxic to the blood forming organs.

Nearly all the barbiturate drugs used as sedatives, have been incriminated at one time or another, but such instances of blood damage are extremely rare from most of these compounds.

The introduction of a new analgesic at the present time is an extremely difficult problem for in the clinical and laboratory test periods,

one suspected incident of depression of white blood count, either in a laboratory animal or human patient, will scare off any further attempts on the part of the manufacturer, to promote his new compound. This has happened at least twice within the past two years, the abandonment of the experimental drug being based merely on suspicion and not on any proven damage produced.

The arsenic containing compounds used in the treatment of syphilis, have been occasionally the cause of purpura or aplastic anemia.

Thiouracil and its derivatives, used in the treatment of hyperthyroidism, have caused considerable trouble because of their occasional production of agranulocytosis. This has developed from all the variants upon the original drug, the frequency of its occurrence apparently being related to the size of the dose necessary for clinical effect and consequently being less frequent with the drugs which are active in smaller dosage. However, none to present date have been free from such action. The drugs introduced more recently for control of epilepsy, particularly Tridone, have as one of the penalties attached to its use, the requirement that a study of the blood be carried out to avoid the production of agranulocytosis.

Gold compounds used in the treatment of arthritis, may in addition to their toxic action on the liver and kidney, occasionally produce aplastic anemia of dangerous degree or an agranulocytosis.

The sulfa compounds with their saving of hundreds of lives which would have been lost from infection without their help, are however, capable of producing damage. Most striking was the action of sulfanilamide, the first compound introduced in therapy, which in an unpredictable 1-3%, would without warnings, suddenly produce a profound degree of hemolytic anemia, which bore no relationship to the almost constant cyanosis which accompanied its use. In addition to the hemolytic anemia, an agranulocytosis appeared in a smaller number of cases,

approximately 0.3%. The succeeding sulfonamide compounds became progressively less dangerous to the blood system, and at the present time, the compounds currently in use, give little concern in this regard.

Extremely disconcerting has been the discovery, during the past year, that one of the extremely valuable antibiotics, Chloromycetin, can be the cause of a profound and occasionally fatal anemia or agranulocytosis.

Most recently added to the list of potentially dangerous drugs, is the compound which is one of the most recent drugs introduced into therapy, namely, Phenylbutazone (Butazolidin) which is used for the treatment of gout and arthritis.

It is interesting and undoubtedly significant, in considering the structural formula of many of these compounds, to find that chemical relationship to Benzol in its ring structure, is found in many of these compounds. This was recognized for aminopyrine, and is to be found in Thiouracil, Phenylbutazone, and even in the only

antibiotic which has been synthetically prepared and exactly described chemically, Chloromycetin. It would appear that study of structure of new compounds might give some clue as to the possibility of their dangerous action.

In considering the use of these drugs, we must bear in mind that the unfavorable and destructive action occurs in a very minute fraction of the number of patients in which they are used. In the vast majority of instances, the action is the favorable one, which is desired. The unfavorable action, occurring once in 10,000 times, must not force from use, drugs which are irreplaceable in producing certain healing results. We must, however, recognize the importance of adequate supervision and recognition of the possibility for harm which such compounds do carry.

DR. STURGIS: Thank you, Dr. Norwood.

Until 1926, we had absolutely no means of treating the macrocytic anemias. In that particular year Minot and Murphy introduced liver and since then there has been a long series of important therapeutic developments including folic acid and vitamin B₁₂. Dr. Conley is to take this topic, which is "The Treatment of Macrocytic Anemias."

TREATMENT OF MACROCYTIC ANEMIAS

C. LOCKARD CONLEY, M.D.

Anemia is always a manifestation of disease and should never be looked upon as a disease itself. When the cause of anemia is not obvious, careful examination of the blood will often provide clues suggesting the nature of the disorder. Anemia characterized by macrocytosis of the red cells always brings to mind the possibility of a deficiency of either folic acid or of vitamin B₁₂. It is important to recognize that not all macrocytic anemias are attributable to deficiencies of these vitamins. An impressive macrocytosis is sometimes seen with other disorders of the hematopoietic system, as for example in certain aplastic and hemolytic anemias. The macrocytic anemia associated with folic

acid or B₁₂ deficiency is a very special type of disorder in that the bone marrow shows an abnormal megaloblastic change which is virtually pathognomonic of deficiency of one of these vitamins.

Folic acid and vitamin B₁₂ are chemically unrelated substances, both of which are required for normal health, growth and development. These vitamins are specifically required for blood formation. The metabolic actions of these vitamins seem to be very closely interrelated so that deficiency of one gives rise to a clinical disorder which simulates that produced by deficiency of the other. Thus the anemia and abnormal bone marrow pattern associated

with B₁₂ deficiency are indistinguishable from those produced by folic acid deficiency. Other clinical manifestations of the deficiency state are also similar. Deficiency of either vitamin may give rise to glossitis with soreness, redness, and papillary atrophy of the tongue as well as other alimentary disturbances including anorexia, nausea, vomiting and diarrhea. It is not always easy on clinical grounds to differentiate deficiency of B₁₂ from that of folic acid. Inadequacy of vitamin B₁₂ may give rise to a very characteristic disorder of the nervous system, namely subacute combined degeneration. This neurologic syndrome is not associated with lack of folic acid; therefore, the occurrence of subacute combined degeneration is always indicative of B₁₂ deficiency. The close metabolic relationships between folic acid and B₁₂ undoubtedly account for the similarity of the two deficiency states. Nevertheless one vitamin cannot supplant the other. It is of interest and importance, however, that a partial deficiency of one vitamin will seem to be overcome by administration of an excess of the other. Because of this fact the therapeutic test is often of little value in the differential diagnosis of these deficiency states.

Neither vitamin B₁₂ nor folic acid is a bone marrow stimulant. Its value as a therapeutic agent is limited to those conditions in which a deficiency of the vitamin is present. In anemias not attributable to vitamin deficiency administration of folic acid or B₁₂ is entirely without effect.

Folic acid deficiency may be brought about by inadequate intake of the vitamin or by defective absorption. In some areas of the world where the diet is grossly inadequate, folic acid deficiency is common. In India, for example, a macrocytic anemia attributable to folic acid deficiency has been frequently encountered. Numerous cases have been seen in certain areas of the southern United States. However, nutritional folic acid deficiency is virtually unheard of in the vicinity of Baltimore and one

should be very hesitant to suggest a diagnosis of nutritional macrocytic anemia in this area. Evidences of folic acid deficiency may occasionally appear during pregnancy, presumably at least in part because of increased demands for the vitamin at that time. The macrocytic anemia of pregnancy which is erroneously called "pernicious anemia of pregnancy" is a folic acid deficiency state. The anemia may be associated with glossitis and gastrointestinal disturbances. These manifestations promptly subside following the administration of folic acid. This disorder is extremely rare in this vicinity. We have seen only 2 cases at the Johns Hopkins Hospital in 5 years. The disorder can be prevented by the prophylactic administration of supplementary folic acid. In view of the great rarity of the condition, it is a question whether folic acid, an expensive substance, should be administered routinely to all pregnant women. Folic acid deficiency, particularly when associated with deficiency of vitamin C, has in rare instances been observed to produce a macrocytic anemia in young infants. This disorder has most often occurred in infants who had inadequate diets and superimposed febrile illnesses. There is good evidence that vitamin C may be concerned with the conversion of folic acid to a biologically more active substance and it is probably for this reason that the combined deficiency is found in infants with this type of megaloblastic anemia. The most common cause of folic acid deficiency which we see is defective absorption of the vitamin from the small intestine. This impaired absorption is most often associated with sprue, a disease in which there are multiple absorption defects. Occasional cases of extensive regional enteritis may also lead to defective absorption of folic acid and a resultant macrocytic anemia. Administration of folic acid to such patients rapidly overcomes the manifestations of folic acid deficiency, but, of course, does not cure the underlying disease. You will note that conditions causing folic acid deficiency are very

uncommon in this part of the world and we do not often have occasion to employ this vitamin therapeutically. When folic acid deficiency is present the oral administration of about 5 mg. per day is usually adequate for satisfactory therapeutic effect. In patients with serious absorption defects it is probably wise to give somewhat larger doses.

Vitamin B₁₂ is a very remarkable substance, deficiency of which gives rise to the manifestations of pernicious anemia. Theoretically, vitamin B₁₂ deficiency could be produced by inadequate diet. However, if such a deficiency occurs at all, it must be extraordinarily rare. The fantastically minute amount of the vitamin which is required, together with the production of B₁₂ by intestinal bacteria, probably account for the rarity of nutritional deficiency states. Pernicious anemia is the syndrome of vitamin B₁₂ deficiency. All of the manifestations of this disease can be attributed to failure of adequate absorption of vitamin B₁₂. The mechanism by which vitamin B₁₂ is absorbed from the gastrointestinal tract seems complex. In order that optimal absorption can take place, an as yet unidentified component of the gastric secretion is required. This gastric component is the old "intrinsic factor" of Castle, while vitamin B₁₂ itself is now considered to be the "extrinsic factor" of Castle's hypothesis. The basic disorder in pernicious anemia is an abnormality of the gastric mucosa as a result of which normal gastric secretion is not produced. For this reason, patients with pernicious anemia have no hydrochloric acid or gastric enzymes in the stomach. Lack of these substances has no clinical effect. However, the deficiency of "intrinsic factor" leads to impaired absorption of vitamin B₁₂ as a result of which manifestations of B₁₂ deficiency eventually appear.

The macrocytic anemia, the alimentary symptoms, the neurological manifestations are all specifically attributable to deficiency of B₁₂. There is no regular time relationship of the appearance of the various symptoms. Thus glos-

sitis or neurological manifestations may appear before the blood becomes abnormal. The term "pernicious anemia" is no longer an appropriate designation for the disease, for the disorder is not pernicious, and we recognize now that it is not primarily an anemia. The treatment of pernicious anemia is extraordinarily simple. Since vitamin B₁₂ is poorly absorbed from the intestine, the absorption defect is circumvented by parenteral administration. Amazingly small amounts suffice. In our experience with a large group of cases, the injection of 45 micrograms of B₁₂ at intervals of 6 weeks has in every case been adequate to maintain complete hematologic and clinical remission for periods of observation which in some cases now exceed four years. During the initial phase of treatment it is advisable to give larger and more frequent doses, particularly when neurologic manifestations are present. The alimentary symptoms subside in a day or two after therapy is initiated. The blood returns entirely to normal within a few weeks, but neurologic changes are unpredictably benefited. If treatment is delayed, permanent neurologic damage may result. It is important to remember that the therapy must be continued for the life of the patient. If treatment is discontinued, relapse will eventually occur. Parenteral therapy is so simple, so completely effective, and so inexpensive, that it seems unwise for physicians to experiment with oral therapy. Vitamin B₁₂ can be absorbed from the intestine of patients with pernicious anemia if adequately large amounts are given. However, the amount required is of the order of 100 times the effective parenteral dose. The administration of a source of intrinsic factor with vitamin B₁₂ enhances absorption and makes possible the use of smaller oral doses. Such preparations are now appearing on the market, but they have not as yet been subjected to long term clinical trial.

Although pernicious anemia is a vitamin B₁₂ deficiency state, administration of folic acid will often produce striking clinical and hematologic improvement in patients with this disease. How-

ever, folic acid does not bring about improvement of the neurologic disorder, which often progresses rapidly during folic acid therapy. When folic acid is administered to patients with pernicious anemia, the blood may remain entirely normal and the only evidence of the disease may be progressive subacute combined degeneration. Because of the widespread use of folic acid in multivitamin preparations, patients with pernicious anemia are appearing with advanced neurological disease in the absence of anemia. The syndrome of subacute combined degeneration should always be considered to be a manifestation of pernicious anemia and should be treated as such, even though the blood and bone marrow are normal.

Vitamin B₁₂ deficiency is rare apart from Addisonian pernicious anemia. Occasional patients develop typical pernicious anemia following total gastrectomy, presumably because the source of intrinsic factor has been removed and vitamin B₁₂ is then poorly absorbed. Rarely

patients with intestinal absorption defects such as occur in sprue may develop evidence of B₁₂ deficiency. An interesting group of patients has been observed in which B₁₂ deficiency has been associated with certain lesions of the small intestine such as diverticulae or resection of a portion of the intestine. The clinical manifestations which these patients present are similar to those of pernicious anemia, except that the gastric secretion may be normal. Treatment is the same as for pernicious anemia.

Conditions in which there is a combined deficiency of both folic acid and B₁₂ are rare. In my opinion, the only condition for which one is regularly justified in administering both vitamins is sprue, a disorder in which multiple deficiency states appear. Except for the conditions which I have mentioned in this discussion, there is little well established indication for the use of folic acid or vitamin B₁₂.

DR. STURGIS: Thank you, Dr. Conley.

HEMOLYTIC ANEMIA

MILTON S. SACKS, M.D.

An understanding of certain physiologic facts about the life span and survival of the red blood cell is fundamental for any discussion of hemolytic anemias. It is now generally agreed that the normal red cell survives in the peripheral circulation for approximately 100 to 120 days. Whenever there is accelerated destruction for one reason or another a hemolytic anemia may ensue. The tempo of destruction determines the clinical picture. Thus the picture may vary from an acute hemolytic anemia due to massive red cell breakdown with associated hemoglobinuria to a subacute process or to one which is of relatively slow tempo and which is characterized as a chronic hemolytic anemia.

Much of the information which we have about the life span of red blood cells is based

upon the technique proposed a number of years ago by Winfred Ashby. Although there have been modifications of the Ashby technique the principle has been retained. It consists, in essence, of introducing red cells which are antigenically different from those of the recipient but yet which will not produce any reaction. One may follow the survival of these "tagged" red cells in the recipient's blood.

A recent extension of the Ashby technique has been the cross transfusion experiment by means of which it is possible to more or less pinpoint the site of difficulty. If one is dealing with a hemolytic anemia in which the basic defect is within the red cell itself, these abnormal cells will show an accelerated breakdown in the circulation of a normal individual; con-

versely, a defect outside the red cell i.e., in the serum can also be detected.

On the basis of the foregoing data, one may attempt to classify this very large and complex group in the following manner.

The intrinsic group includes those hemolytic anemias in which there are hereditary defects in the red cell (Sickle Cell Anemia, congenital hemolytic jaundice, Mediterranean anemia). Hemolytic anemias of extrinsic origin include those due to chemical or physical agents, such as Dr. Norwood referred to, those due to bacterial infection (*Clostridium Welchii* sepsis); and a very large group in which there is apparently an autoantibody capable of reacting with the individual's own red blood cells.

It is, of course, impossible to go into considerable detail about all of these entities, so that I have chosen simply to comment on certain significant aspects of the hemolytic anemias which I consider important.

One interesting development of recent origin has been the characterization of hemoglobins in the various hereditary hemolytic syndromes. Studies on sickle cell disease by means of electrophoresis have demonstrated the existence of an abnormal hemoglobin in the red cells of these individuals. This type of hemoglobin is designated Hemoglobin S. Several related abnormal varieties have also been discovered. The clinical significance of these findings still remains to be determined.

In regard to congenital hemolytic jaundice, the importance of family study, cannot be over emphasized. A common clinical experience with regard to this disease and one emphasized many years ago is the aphorism that "these patients are more jaundiced than ill." Patients with congenital hemolytic jaundice are not infrequently seen who have reached middle age with virtually no clinical difficulties. A very important question arises with regard to these patients which might be phrased "to splenectomize or not to splenectomize." There are many advocates of prophylactic splenectomy even in such cases. The occurrence of repeated

hemolytic crises is an important indication for splenectomy.

We have been interested in certain of the genetic aspects of sickle cell anemia. The incidence of the sickling trait in the American negro is approximately nine per cent. It is of great interest that careful studies in scattered areas of the African continent have indicated an average incidence of the sickle cell trait of approximately fourteen per cent. In other words, in a period of some three hundred years there has been a gradual diminution in the incidence of the sickle cell trait in this country.

It needs to be emphasized that this disease occurs in at least two clinical forms, as the trait and as the active disease itself. When the gene responsible for this abnormality is present in a heterozygous manner the affected individual exhibits only the sickle cell trait. When it is present in the homozygous state, the active disease will result.

An important development in the diagnosis of this disease is the use of a reducing agent for the rapid demonstration of the sickling phenomenon. Sodium meta bisulfate is one of the most convenient and useful agents for this purpose. By this technique it is possible to obtain an answer within some fifteen minutes.

Mediterranean anemia, as you know, also exists in two forms. One, which is usually referred to as *Thalassemia Minor*, often exists without clinical symptomatology. The abnormal gene when present in a double dose (homozygous) results in the entity *Thalassemia Major*. In our experience this disease is most commonly seen in this country in individuals of Italian or Greek ancestry. It is of considerable interest to note that within recent years instances of sickle cell anemia in white individuals, usually of the latter ancestry have been described.

In the study of large family groups there is evidence that one may encounter both the sickle cell trait and the Mediterranean anemia trait in various members of the group.

I should like briefly to review the hematological and biochemical characteristics of the hemolytic anemias. The anemia is usually of a normocytic, or occasionally macrocytic type. The leukocyte count is usually normal. It may be increased in the presence of a crisis. Platelets are usually normal although there is an interesting group of cases of acquired hemolytic anemia in which thrombopenia and anemia have been observed together. The marrow usually shows there is a compensatory erythroid hyperplasia of a normoblastic type. Osmotic fragility is usually increased. An examination of the blood smear will reveal polychromatophilia, the presence of spherocytes, and frequently a significant normoblastosis.

The biochemical features include hyperbilirubinemia due to the indirect type of bilirubin. Occasionally, immediately after an acute massive hemolysis, there will be hemoglobinemia and hemoglobinuria. The urine and feces show increased urobilinogen excretion.

In the group of acquired hemolytic anemias are included all the entities exclusive of the hereditary syndromes. In actual practice, the term acquired hemolytic anemia has been considered synonymous with the type associated with an auto-antibody. The acquired types do, however, include those due to chemicals, drugs, bacterial infections, etc. I should like to place greater stress on those with a basic immunologic disorder. Even within this group there are a variety of types. One type, known for a long time, is the paroxysmal cold hemoglobinuria associated with some cases of lues. The mechanism of this type was described many years ago and is embodied in the classical Donath-Landsteiner Test. By this procedure one can demonstrate an antibody present in the individual's blood which is capable of uniting with his own cells at low temperatures. Hemolysis occurs with raising of the body temperature.

During the past five or six years a great deal of work has been done on the pathogenesis of

acquired hemolytic anemia due to the presence of an auto-antibody which unites with the patient's own erythrocytes. The Coombs' test, introduced about 1947, has offered a means of demonstrating this antibody adsorbed on the red blood cell. The antibody is now recognized to be a panagglutinin capable of reacting with virtually all normal human cells. It may be one which is most active at 37° C. (warm agglutinin) or one which is most active at refrigerator temperature (4° C.). We believe the type of antibody, warm or cold agglutinin, may actually determine the clinical syndrome. For example, in primary atypical pneumonia, an occasional case of acquired hemolytic anemia associated with a high type of cold agglutinins is sometimes seen. This type of acquired hemolytic anemia usually has a better prognosis than the type associated with a warm agglutinin.

Of particular interest in our study of acquired hemolytic anemia is the recognition that the hemolytic anemia may occur only as a complication of some other underlying disease. In a review of the literature of the past 10 years it was interesting to note that of eighty-five cases of secondary acquired hemolytic anemia most were associated with primary atypical pneumonia, various types of lymphoma, and certain collagen diseases, notably acute disseminated lupus erythematosus.

The management of acquired hemolytic anemia can only be touched upon briefly in the time remaining. Cortisone and ACTH often cause dramatic remissions in these cases. Relapses are, however, common. Splenectomy should be employed when medical therapy fails. Unfortunately, it also is not uniformly successful. Recently, nitrogen mustard has been employed in an effort to produce a "medical splenectomy." The prognosis in this disease has been definitely improved by these measures. Much still remains to be done.

DR. STURGIS: Thank you, Dr. Sacks.

Our next speaker will be Dr. Cooley, who will discuss the Therapy of Leukemia, Hodgkin's Disease and Allied Disorders.

THERAPY OF LEUKEMIA, HODGKIN'S DISEASE AND ALLIED DISORDERS

ROBERT N. COOLEY, M.D.

The present day treatment of leukemia, Hodgkin's disease and allied disorders depends in large part upon the administration of agents which are toxic to the abnormal cellular growths which are the main feature of these diseases. Whether it be radiation, aminopterin, urethane or nitrogen mustard, all of these substances have a direct toxic or destructive effect upon the abnormal cells originating primarily in the bone marrow, spleen and/or lymph nodes. Unfortunately these agents have a similar action upon the normal cells of these same organs and the differential of susceptibility between the healthy and the neoplastic* tissue is small. For this reason present day therapeutic agents cannot be pushed to the point of complete destruction of all abnormal tissue growth for fear of irreparable damage to the essential normal tissues such as the bone marrow and the lymphatic system. Therefore, except under certain rare circumstances where the disease is well localized and easily accessible, cure is impossible and the best that can be expected is prolonged palliation.

The ideal therapeutic agent should have a highly selective destructive action on the abnormal cellular tissues and a relatively mild and benign effect on the surrounding normal organs. Another line of attack might be an agent, hormonal in nature, which would curb the otherwise unregulated neoplastic-like tissue growth and make it again subject to the usual growth restraints which the body provides naturally. Such agents are ACTH and Cortisone and more will be said about these by another essayist on this panel. Unfortunately the action of ACTH and Cortisone is often unpredictable and may be short lived and evanescent. The ideal treatment agent has not yet emerged.

Acute leukemia, untreated, is a rapidly pro-

gressive disease which terminates fatally in one to six months. Radiation therapy is of almost no benefit and it is the opinion of several observers² that it may hasten the inevitable fatal outcome. Rarely, however, when massive enlargement of lymph nodes or collections of leukemic tissue produce tracheal obstruction or cardiac embarrassment, radiation may be directed toward these masses with the hope of reducing their bulk. Under these circumstances the dose must be small in order to 1) avoid further initial swelling of the masses and 2) prevent injury to an already badly damaged hemopoietic system.

Aminopterin and related anti-folic acid compounds have been in use for several years and it has been well established that following their proper use 60% of children and 20-30% of adults with acute leukemia will be improved. Occasionally the response has been striking and moribund children have been restored to a seemingly normal state. More often, however, there has been a gradual recession of the clinical signs and symptoms associated with a decrease in the number of abnormal circulating elements in the blood and bone marrow. Following a remission an attempt may be made to establish a maintenance dose, but the patient must be closely observed because of the marked toxicity of the anti-folic substances. The most pronounced of these effects are 1) injury to the bone marrow and 2) injury culminating in destruction of the surface epithelium of the digestive tract. One of the earliest manifestations of a toxic effect is soreness of the tongue and soft palate followed by ulceration and this is an urgent indication to suspend the use of the medication. Eventually these patients relapse, become refractory to the drug and succumb to leukemia or one of its complications. There can be no doubt, however, that the survival period,

* "Neoplastic" is used advisedly since there is still some dispute as to whether Hodgkin's disease and the leukemias are true neoplasms.

of those patients who respond, is lengthened and that aminopterin or one of its associated compounds is the drug of choice in most cases of acute leukemia.

Like aminopterin, ACTH and Cortisone produce their most favorable effects in children with acute leukemia; of those about one-half will respond favorably. In adults less than 10% show any demonstrable improvement. Although these substances have been in use for some years they are still in an experimental stage and should be used only by those physicians who are familiar with their potentialities and dangers.

In chronic leukemia again we are dealing with an incurable disease which eventually terminates fatally. Treatment is therefore palliative and results are measured by 1) duration of life and 2) duration of comfortable productive life. A number of older surveys^{2, 7, 14} have shown that following the development of symptoms due to chronic myelogenous leukemia the average duration of life is about 3 years. In a significant study Minot⁷ and his associates found 52 cases of chronic myelogenous leukemia who had received no radiation or other specific therapy in which the duration of life following the onset of symptoms was 3.04 years. This was compared with a duration of life of 3.5 years in 72 patients with the same disease treated by x-rays. A summary of similar findings recorded by other observers² is shown in Figure 1 and this suggests that radiation produces only a very short and insignificant prolongation of life. However, all observers agreed that x-ray treated patients were definitely more comfortable and productive than those who received no specific therapy. Also more recently Osgood⁹ and Seaman found that more than 80% of the residual life of their radiation treated patients was spent in productive activities. Also Lawrence^{4, 5} and his co-workers have found average survival times of 3.7 years in chronic myelogenous and 4.1 years in chronic lymphogenous leukemia treated with radioactive phosphorus. Furthermore sev-

eral patients in each group are still alive. Consequently, there can be little doubt that radiation therapy in experienced hands has greatly improved the period of comfortable existence and slightly increased the actual longevity of patients with chronic leukemia.

The most commonly used chemical agents in the treatment of chronic leukemia are arsenic, urethane, triethylene melamine and nitrogen mustard. Wintrobe and Hasenbush¹⁴ found that arsenic was definitely inferior to roentgen therapy in the production of satisfactory remissions and this is the opinion of other observers.² Urethane may produce very satisfactory remissions and can be used as a primary means of treatment. However its effects are not easy to control and the margin between therapeutic and toxic dosages is quite narrow. Triethylene melamine and nitrogen mustard have a small field of usefulness in cases which are refractory to radiation. As a primary form of treatment they are somewhat less reliable and more difficult to control than radiation therapy.

Currently there are two radiation modalities, namely: 1) external x-rays administered a) locally to the spleen or less frequently to the liver or mediastinum and b) whole body radiation; 2) radioactive phosphorus administered by mouth or vein. None of these has clearly demonstrated its superiority over the other as a means of administering radiation. Of much

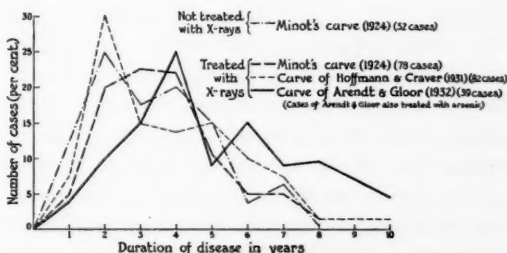


FIG. 1. Chart showing the duration of life in 4 series of cases of chronic myelogenous leukemia treated as indicated. Reproduced from, "Leukemia and Allied Disorders." The MacMillan Co., New York, 1938. By courtesy of Dr. C. E. Forkner, author.

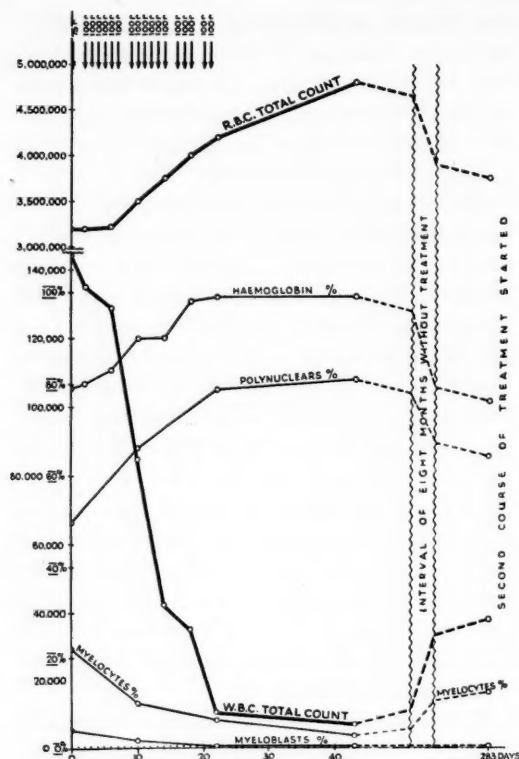


FIG. 2. Chart showing blood changes following administration of x-radiation to the spleen in chronic myelogenous leukemia. Reproduced from, "The Treatment of Malignant Disease With Radium and X-Rays," by R. Paterson.

greater importance is the amount and timing of the radiation rather than the means by which it is given. However, a review of seven recent papers^{1, 4, 5, 6, 9, 12, 13} indicates that a majority of the authors preferred radioactive phosphorus particularly in chronic myelogenous leukemia. Where external x-ray therapy was mentioned whole body radiation was preferred. However, where the spleen is greatly enlarged and is producing symptoms local radiation will reduce the size quicker and is therefore preferable. Radioactive phosphorus in the usual doses rarely produces radiation sickness in contrast to an incidence of 10-20% of this condition in patients receiving splenic irradiation. The practice at The Johns Hopkins Hospital is to ad-

minister x-radiation to the site of the largest collection of leukemic tissue which is often the spleen and less commonly the liver, mediastinum or cervical areas. If there are no large localized collections whole body radiation is given. The radiation should be administered in small daily doses until the blood count begins to drop significantly following which treatments are given every second and finally every third day until the white blood count approaches 20,000. At this point treatments are suspended and the count usually stabilizes in the neighborhood of 10,000. The principle effects of the radiation are to (Fig. 2): 1) reduce the total white blood count; 2) reduce the number of immature cells in the peripheral blood; 3) increase the red count, hematocrit and hemoglobin. Accompanying these blood changes there is usually a clinical remission in the patient's disease.

Following the initial course of treatment the patient should be followed at four to six weeks intervals. At the first sign of renewed leukemic activity such as an increasing white blood count, weakness, anemia or weight loss further radiation treatment should be considered. Further deterioration of the patient's condition should not be permitted because of a mistaken idea that treatment will be more effective under such circumstances. Eventually the disease will become refractory to radiation and this remains one of the unsolved problems in the treatment of leukemia. When the disease becomes refractory to one form of radiation, another may be tried such as a switch from splenic irradiation to whole body irradiation. Nitrogen mustard or triethylene melamine also may be tried. During the later refractory stages, however, the disease tends to become rapidly progressive despite all forms of treatment.

Anemia, which is a rather consistent feature of chronic leukemia, is best treated by blood transfusions. In general, if the hemoglobin is below 10 grams transfusions are indicated and are preferably given before the patient is sent for radiation therapy. Although not proven, it is

a clinical impression that those patients who have had their anemia corrected are less susceptible to radiation sickness and in general tolerate their radiation better than those who are anemic. Following successful treatment the anemia tends to improve spontaneously, but this is a slow process and is not sufficient when the anemia is well marked.

One should be especially alert for the onset of infections since leukemic tissues are particularly susceptible to bacterial invasion. Chronic infections likewise should be suspected and searched for. The free use of antibiotics such as penicillin is most helpful in dealing with these possibilities.

Several important observations have had an effect on current thought regarding the treatment of Hodgkin's disease and lymphosarcoma. These are: 1) A number of patients have survived for 10 years or longer following treatment; 2) in a majority of these patients the disease was limited to one set of nodes in the cervical region and was treated by surgery or obliterative x-ray therapy or both; 3) lymph nodes of Hodgkin's disease removed following the administration of 3000 roentgens of x-radiation in 4 weeks may show a severe damage or death of all cellular structures and 4) the best reported results have been obtained by vigorous radiation treatment to both the lymph node group in which the disease was first manifest and the adjacent lymph node areas. These observations might lead to the following assumptions: 1) the disease initially is a localized process in a single lymph node group and if treated vigorously while still localized, the disease might be obliterated; 2) the disease spreads by extension to adjacent lymph node areas so that inclusion of these areas in the field of radiation would improve the chances of reaching all of the disease. These assumptions are by no means proven. However, our current practice in patients with involvement of only one group of nodes or preferably a single node in the cervical region is to give obliterative radiation (3000 r.

in 3-4 weeks) to this area followed by considerably smaller doses (1000 r.) to the opposite cervical and mediastinal nodes. The same plan might be applied to a single axillary node. Primary involvement of other lymph node groups, however, such as the mediastinum or inguinal region, provide such a wide area of possible dissemination that such a treatment policy is impossible.

Slaughter and Craver¹¹ found a five year survival of 17.7% in a group of 265 patients with Hodgkin's disease treated mainly by x-radiation. On the other hand, Peters¹⁰ found that out of 113 treated patients 48 survived 5 years or longer. She classified her results according to the extent of the disease when treatment was begun.

	5 yr. sur- vival	10 yr. sur- vival
Stage I—Involvement of a single lymph node region (35 cases).....	88%	79%
Stage II—Involvement of two or more proximal lymph node regions of either the upper or lower trunk (32 cases).....	72%	21%
Stage III*—Involvement of two or more lymph node regions of both upper and lower trunk (46 cases).....	9%	0%

* More than 90% of the stage III cases had constitutional symptoms when first seen.

The extent of the disease at the time treatment was begun was thus shown to be one of the most important factors in determining the ultimate length of survival. The presence of constitutional symptoms in particular indicated a rather poor prognosis. Peters was inclined to attribute good results in part to the plan of radiation treatment which was followed. This consisted of intensive irradiation of involved nodes with precautionary treatment to adjacent lymph node groups.

Unfortunately, in Hodgkin's disease as it is seen today, more than 70% of the patients are in too advanced a stage to benefit from radical therapy. Therefore, in this larger group treatment is conservative and the primary objective is to make the patient comfortable. Even

though the disease may involve several lymph node areas x-radiation may still be the treatment of choice. However, where many groups of nodes are involved, or when the nodes are not easily accessible or easily localized as in the retroperitoneal region, or when there are marked constitutional symptoms, nitrogen mustard may provide quicker and more satisfactory relief. Also the judicious use of nitrogen mustard may materially reduce the number of x-ray treatments necessary to reduce the size and extent of widespread lymphadenopathy. Eventually most of these cases become refractory to radiation and nitrogen mustard therapy is indicated. Unfortunately remissions produced under such circumstances are usually of short duration.

Lymphosarcoma, reticulum cell sarcoma and giant follicular lymphoblastoma are radiosensitive tumors although they vary considerably in their response to treatment and in their prognosis. Initially they appear to originate in a single node or group of nodes. After varying periods of time they tend to spread to adjacent lymph node areas and then may become widely disseminated throughout the body. Treatment problems are therefore similar to those of Hodgkin's disease. Regional treatment may be given to cervical, axillary or inguinal regions in which an attempt is made to administer 2500-3000 roentgens to both the primary site of the disease and the surrounding lymph node areas. However, if the disease is recurrent following previous treatment or is initially quite extensive, smaller doses are given to each local area of involvement, the main objective being to produce palliation. Nitrogen mustard is somewhat less effective than when used in Hodgkin's disease, but is sufficiently valuable to be used when there is 1) refractoriness to radiation, 2) diffuse or generalized disease and 3) poorly defined or relatively inaccessible tumor masses.

Treatment in general is not satisfactory as less than 40% of patients will survive 5 years or longer. Reticulum cell sarcoma probably has

the worst outlook since this condition responds poorly to both radiation and nitrogen mustard. Lymphosarcoma in children runs a rapidly progressive course. In older individuals the course is variable and somewhat unpredictable. Numbers of long term survivals have been observed. Giant follicular lymphoblastoma, by virtue of its slow natural course and its marked radiosensitivity, gives by far the best prognosis. The average duration of life in this condition is about six years and death is often due to a supervention of Hodgkin's disease of lymphosarcoma.

SUMMARY

The present day treatment of leukemia, Hodgkin's disease and allied disorders is mainly palliative because: 1) the tendency of these diseases to become widely disseminated before treatment is begun; 2) most treatment agents are toxic or destructive to normal organs and consequently cannot be given in sufficient dosage to permit complete destruction of all abnormal or neoplastic tissue.

The average duration of life of treated chronic leukemia following the onset of symptoms is about $3\frac{1}{2}$ -4 years. Numbers of long survivals have been observed and are not unusual. Following proper treatment about 80% of the residual life of these patients will be spent in comfortable, productive activity.

In Hodgkin's disease and lymphosarcoma the average duration of life is about 3 years, but numbers of long term survivals have been observed. Treatment may produce satisfactory short term palliation. Occasionally treatment may be responsible for a long term survival and aggressive radiation treatment of well localized Hodgkin's disease has given some encouraging results and seems to be justified.

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DR. STURGIS: Thank you, Dr. Cooley.

ACTH AND CORTISONE IN THE TREATMENT OF HEMATOLOGIC DISORDERS

CYRUS C. STURGIS, M.D.

There is no convincing evidence that ACTH or cortisone permanently cures any disease by removing its underlying cause. On the other hand, they may produce prolonged remissions in some pathologic states, or so alter the situation temporarily that other curative factors may become effective. In certain hematologic conditions, these agents exert a salutary effect and serve a useful purpose, although with the exception of some cases of idiopathic thrombocytopenic purpura and possibly a rare case of idiopathic acquired hemolytic anemia, there is no indication that they are controlled permanently.

THE EFFECT OF ACTH AND CORTISONE ON THE NORMAL CIRCULATING BLOOD

First, let me make a few remarks concerning the effects of cortisone and ACTH on the normal constituents of the circulating blood. When 25 milligrams of ACTH are given subcutaneously,

there is an almost immediate decrease in the number of circulating eosinophils, which is sometimes followed by a rebound, and then a fall within four to six hours after the injection. These changes occur so regularly that they have been employed as a functional test of the adrenal cortex. With continued administration of this agent, there is usually a persistent absence of the eosinophils from the blood stream. This eosinopenia is the most constant change in the circulating blood following the administration of ACTH or cortisone. Hence it is the most reliable indication of the intactness of the adrenal cortex, if this decrease in the numbers of eosinophils follows ACTH injection. It is thought that the reduction in eosinophils is due to an inhibition of the rate of formation and release of these cells from the bone marrow, rather than to their accelerated destruction after they have reached the circulating blood.

Other changes also are observed in the peripheral blood following the administration of these

agents. They are as follows: A slight reduction of lymphocytes occurs usually within four hours after the injection of 25 milligrams of ACTH and this is followed by a moderate lymphocytosis often associated with the appearance of a few immature lymphocytes. Immediately after the injection there may be a slight transient fall in neutrophils, followed within one to four hours by an increase in the number of these cells, which reaches a maximum within 48 hours. This is of some interest because of the possible beneficial effects these therapeutic agents may have in the treatment of agranulocytosis. In summary, ACTH or cortisone produces an eosinopenia, a decrease in the number of circulating lymphocytes, and an increase in the total leukocyte count of the neutrophils. In the normal person, there might be a slight actual increase in the number of red blood cells and platelets but these changes are of minor importance and they may be obscured by dilution effects.

DOSAGE AND MODE OF ADMINISTRATION OF ACTH AND CORTISONE

In all of our patients, we have given either ACTH in doses of 25 milligrams subcutaneously every six hours or cortisone orally 75 milligrams every six hours. Usually such therapy has not been continued longer than 14 days although occasionally the period has been extended to 21 days. When a maintenance dose has been given, it has been restricted to a maximum of 75 milligrams a day. In all instances the patient has received a low sodium (800 milligrams) diet during the period of ACTH or cortisone administration. No important untoward symptoms have been observed during the course of therapy.

THE EFFECTS OF ACTH AND CORTISONE IN VARIOUS HEMATOLOGIC CONDITIONS

In the remainder of the time allotted to me, the discussion will be limited to the effects of ACTH and cortisone in the treatment of the

following conditions: idiopathic thrombocytopenic purpura, acute acquired hemolytic anemia, leukemia, multiple myeloma, Felty's syndrome and Hodgkin's disease. With the possible exception of acute agranulocytosis, in which it may be of some therapeutic value, there are no other hematologic disorders in which it exerts an appreciable beneficial effect.

IDIOPATHIC THROMBOCYTOPENIC PURPURA

In the past, patients with this condition either continued to suffer from the disease, succumbed to its effects, experienced a spontaneous remission, or were subjected to a splenectomy which proved to be curative in about 80 per cent of the group so treated. With the introduction of ACTH and cortisone, however, a new and useful agent has been made available for this condition. We have now treated 22 patients with one or the other of these two drugs and in 93 per cent a remission has followed within two to three weeks. The improvement in some patients has not always been complete but in every instance the platelets have increased to at least 75,000 per cubic millimeter and the excessive bleeding has been controlled.

In our group, when a remission has been produced, usually after two weeks of medication, the drug has been omitted and the patients kept under observation. In 60 per cent of these patients there has been a relapse in the bleeding tendency within 7 to 14 days, and splenectomy has been performed with satisfactory results after a second therapeutic remission has been produced either with cortisone or ACTH.

In 40 per cent of the patients after a therapeutic remission has followed the use of either one of these drugs, it has been maintained without additional treatment to the present time which provides a follow-up period varying from a few months to a maximum of two and one-half years.

In summary, it is certain that a remission, partial or complete, will be induced in prac-

tically all patients with idiopathic thrombocytopenic purpura by the administration of ACTH or cortisone. In 40 per cent of such patients, the improvement is of long duration and may be permanent. In 60 per cent, there is a rather prompt relapse, but a second remission can be induced preoperatively, which is a great advantage because splenectomy can then be performed with less risk as the bleeding tendency is controlled.

IDIOPATHIC HEMOLYTIC ANEMIA

This condition, formerly regarded as a rare hematological disorder, now appears to be increasing somewhat in frequency. We have treated nine cases with either cortisone or ACTH and all have exhibited definite evidence of worthwhile improvement. One patient who had been ill for two years with such an anemia, severe enough to require blood transfusions, was treated for two weeks with ACTH, 25 milligrams every six hours, and the medication was then stopped. She developed a complete and prompt remission and remains perfectly well without additional treatment after a period of two years' observation. All of the remaining patients relapsed shortly after medication was stopped, necessitating a second course of treatment which again controlled the anemia, and permitted splenectomy under safer conditions. This form of medical treatment, therefore, at least reduces the hazard of splenectomy in such patients and occasionally produces a prolonged remission and possibly a complete cure. In addition, the use of these therapeutic agents may control the abnormal destruction of transfused red blood cells by hemolysis, which sometimes occurs in patients with this form of hemolytic anemia.

LEUKEMIA

In my opinion, neither ACTH nor cortisone has a place in the treatment of *chronic leukemia* except in patients with multiple myeloma which is now generally considered to be subleukemic

plasmocytic leukemia, and in patients with chronic leukemia who have an acute exacerbation of the disease. In cases of *subacute and acute leukemia*, either in adults or children, however, such medication may serve a useful purpose.

In about 10 per cent of the adults, and a much higher proportion of children, often considerable and sometimes dramatic transient improvement is attained. For example, one of our patients, a male, 25 years of age, with acute granulocytic leukemia, was treated with 100 milligrams daily of ACTH for 10 days. The white blood cell count dropped from 300,000 per cubic millimeter, of which practically all were blasts, to 4,000 per cubic millimeter, with a complete disappearance of immature cells from the circulating blood, and a return of the bone marrow to normal. His spleen, which had been considerably enlarged, was no longer palpable, and he had an apparent complete restoration to health without the slightest evidence of leukemia which could be demonstrated by clinical means. After a period of five weeks he suffered a severe relapse. Following the same medication, a second perfect remission was induced which persisted for about three weeks. Treatment during the third relapse did not result in improvement and the condition terminated fatally although the same medication was given.

In children the results are somewhat better as about one-third develop temporary remissions, and an additional group show clinical improvement although evidence of this in the blood or bone marrow is lacking. The possibility of using this form of therapy in all acute and subacute forms of leukemia should be considered, either alone or in conjunction with folic acid antagonists medication. In terminal cases of chronic leukemia it also deserves a trial as it gives some comfort to the patient.

MULTIPLE MYELOMA

In my opinion, the treatment of choice of multiple myeloma is the roentgen ray. Urethane in daily doses, beginning with 0.3 grams t.i.d.

and increasing gradually to tolerance or until a daily dosage of 3.0 grams daily is reached, may give some symptomatic relief. The nausea which the drug causes, however, has prevented its extensive use in my experience. Radioactive phosphorus (P^{32}) has been used but probably is not as satisfactory as roentgen irradiation. In general, I believe that the patient should first be treated with the roentgen ray and when this becomes ineffective then cortisone should be used. This should first be given in doses of 75 milligrams every six hours for a period of 10 to 14 days, and then discontinued or a maintenance dose of 75 milligrams daily may be given.

When cortisone is given for 10 to 14 days and then discontinued, the patient often obtains complete symptomatic relief within a few days after the beginning of treatment and this may continue for two or three months. A second course and sometimes multiple courses may produce similar remissions of equal duration, but eventually the patient will become refractory to further similar therapy. Additional evidence of the beneficial effect of this medication is to be found in the reduction in the plasma globulin which is usually higher than normal in the untreated patients, a fall in the non-protein nitrogen of the circulating blood, and a decrease in the immature plasmocytes present in the bone marrow. Although a maintenance dose of 75 milligrams daily may be tried with good results, it too will become ineffective eventually.

FELTY'S SYNDROME

As you know, Felty's syndrome is characterized by the manifestation of rheumatoid arthritis, splenomegaly, leukopenia, lymphadenopathy, loss of body weight and sometimes cutaneous pigmentation. In some instances the white blood cell count may be below 1,000 per cubic millimeter and the neutrophils less than 30 per cent. As cortisone and ACTH have a beneficial effect both on the arthritis and the changes in the blood, and as splenectomy appears to benefit some of these patients, it has been of interest to observe the results obtained

from the use of these drugs in this disorder. In four patients whom we have treated, it was noted that all had striking and immediate improvement in joint manifestations and an increase in the white blood cell count.

Although in all four patients so treated there was a prompt and gratifying improvement, this was purely transient as in all a complete relapse occurred immediately following the discontinuance of the medication. In our opinion, splenectomy produces a much more satisfactory response, and should be given consideration as a form of treatment in all patients in whom this syndrome is well established.

HODGKIN'S DISEASE

Our experience does not indicate that this disorder should be treated with ACTH or cortisone except in the end stages when the patient has become refractory to roentgen irradiation and nitrogen mustard therapy. When such a state does occur, however, then either ACTH or cortisone may be employed and worthwhile results may follow. For example, one patient of ours, a fifteen year old boy with Hodgkin's disease, after being benefited by both the roentgen ray and nitrogen mustard, was no longer able to tolerate either form of medication as both provoked severe and persistent vomiting. As a trial, he was given 200 milligrams of cortisone for 14 days and then given a maintenance dose of 75 milligrams daily. From the beginning of cortisone therapy he was placed on an 800 milligram low sodium diet. His appetite increased remarkably, he developed a mild euphoria, and subsequently was able to tolerate both roentgen ray and nitrogen mustard therapy. Although the enlarged lymph nodes did not recede, there was a gain in body weight of 42 pounds in six months. This medication added six months of satisfactory life to his existence, which permitted him almost normal activity. There appears to be a place, therefore, in the far advanced cases of Hodgkin's disease for the use of cortisone or ACTH therapy which may produce a temporary partial relief of symptoms.

QUESTION AND ANSWER PERIOD

Q. DR. STURGIS: Dr. Conley, discuss briefly the value of iron in the treatment of anemias and the most suitable preparations.

DR. CONLEY: Iron has a very limited use in the treatment of anemia. It is of tremendous value in the treatment of anemias which are due to iron deficiency. When anemias are caused by iron deficiency, iron is specifically effective in causing correction of the anemia. Iron deficiency in infants and young children may be the result of inadequate iron intake, as in infants who are receiving a diet which consists only of milk. In adults, however, iron is required in very small amounts except by individuals who are bleeding. The occurrence of iron deficiency in adults is virtually pathognomonic of blood loss. The administration of iron will correct the anemia. It obviously does not correct the cause of the hemorrhage, so that the treatment of the patient consists not only of administration of iron, but of locating and correcting, if possible, the bleeding lesion. The administration of simple iron salts is all that is required to produce a therapeutic effect. Ferrous sulphate, for example, is perfectly adequate in amounts of a gram or two per day. Some patients find that they are unable to tolerate this because of gastrointestinal disturbances, and then other iron containing compounds may be used, such as ferrous gluconate. There are certain proprietary preparations which are well tolerated. One which incorporates iron in a colloidal complex is particularly well tolerated. There is important reason not to combine iron with other hematinic agents. The administration of a therapeutic agent provides a final diagnostic test. If the patient responds to the agent, then you prove that he needed it. If you combine iron with folic acid, vitamin B₁₂, and whatnot, if response occurs you don't know to what the patient may have responded.

Q. Should splenectomy be done in leukemia, if so, when?

DR. STURGIS: There is one rare possible

indication for splenectomy in leukemia and that is the development of a secondary hypersplenism which in my opinion does occur occasionally. One may suspect this complication in a case of leukemia when the patient develops a slight icterus, the blood bilirubin is slightly or moderately elevated, repeated blood transfusions fail to maintain the red blood cell count as well as one would expect, and there is an elevated reticulocyte count. If the spleen were removed when such a condition is present, it might be easier to control the associated anemia and possibly the purpuric manifestations. I have never observed a patient with leukemia in whom I thought splenectomy was indicated, but others are more optimistic about the results of the operation.

Q. DR. STURGIS: Dr. Norwood, would you discuss briefly the diagnosis and prognosis of monocytic leukemia?

DR. NORWOOD: Monocytic leukemia must be considered first in light of the fact that approximately 90% of the cases are acute leukemias. It follows then, that the response to treatment will not be encouraging and that the life expectancy is short. The fact that monocytic leukemia is more frequently diagnosed at the present time than it has been in the past, probably depends a great deal on the fact that it is an acute leukemia and that the more acute the disease, the more immature the cell forms observed. The more immature the cell form, the greater the difficulty of classification, so that the ultimate diagnosis of type may represent mainly the opinion of the examiner. To establish the diagnosis, smears must show the cells recognizable as monocytic in type, and for this, the most important point is the characteristic folding and doubling-over of the large, rather coarsely granular nucleus. From the clinical standpoint, we have the picture of acute leukemia, usually with purpuric manifestations. Enlargement of the glands is not striking. Enlargement of the spleen is also not striking, in

fact it may be scarcely palpable. Of the distinctive clinical features, I think infiltration of the mucous membranes, particularly of the mouth and gums, is most suggestive. It is by no means absolutely diagnostic since we see the same infiltration in other conditions. However, we see it so much more frequently in monocytic leukemia, that if we have a patient presenting the purpuric syndrome and the leukemic blood picture with intense infiltration and hyperplasia of the gums, I would certainly think very much of monocytic leukemia as a possible diagnosis and would look for other diagnostic support. As to the treatment, unless ACTH or Cortisone will give a temporary remission, I think that monocytic leukemia offers a rather discouraging therapeutic outlook.

Q. DR. STURGIS: Dr. Cooley, discuss briefly the treatment of polycythemia rubra vera.

DR. COOLEY: The treatment of this disease centers around the control of the red blood cell and total blood volumes. As an initial step a series of phlebotomies may be done until the packed red blood cell volume reaches 50-55%. The symptoms of the disease will often be relieved by this procedure alone. In order to maintain the blood within a normal range radioactive phosphorus is the preferable agent. It is given in sizeable doses and is continued until the blood count reaches a normal level and it suffices as a rule to produce remissions lasting from one to two years. The course of the disease is typically prolonged and the average duration of life is about five years. As the disease continues through remissions and relapses complications frequently enter the picture. A certain number of patients die with acute leukemia and others succumb to cerebrovascular accidents. After the disease enters the second decade of survival chronic leukemia becomes a real threat and about ten per cent of all cases of polycythemia vera die with this condition. Some have attributed this to attempts to control the disease by radiation. However this seems unlikely since chronic myelogenous leukemia was a frequently

observed complication before radiation was used as a treatment agent.

Q. DR. STURGIS: Dr. Sacks, will you discuss briefly the indications for splenectomy?

DR. SACKS: There seems to be no doubt that the performance of splenectomy in congenital hemolytic jaundice alleviates most of the clinical symptomatology from this disease. Although the intrinsic defect in the red cell persists, anemia no longer becomes an important factor. In acquired hemolytic anemia, as Dr. Sturgis has pointed out, one occasionally will get a complete remission or even cure by medical means, particularly Cortisone or ACTH, but more often in acquired hemolytic anemia these agents are adjunctive therapy for splenectomy. Of course splenectomy here does not uniformly guarantee the excellent results seen in congenital hemolytic jaundice, but it is an important mode of therapy. In patients with idiopathic thrombocytopenic purpura, unless a sustained remission can be induced by Cortisone, splenectomy should be considered. Aside from these entities, the other reasons for splenectomy are somewhat controversial and would require longer discussion. For example, the place of splenectomy in Banti's syndrome could be discussed at some length if time permitted.

Q. What is the current status concerning the usefulness of TEM,—triethylene melamine?

DR. STURGIS: Triethylene melamine has two possible advantages, first it can be given orally, and it acts in a way similar to nitrogen mustard in Hodgkin's disease. Second, it is also effective in the treatment of the acute and subacute leukemias. It has one serious objection in my opinion, and this is that the toxic dose is close to the therapeutic dosage. A slight overdose may result in aplasia of the bone marrow. Especially to be feared is a serious reduction in the blood platelets and the neutrophils of the circulating blood. Although others assume a more liberal attitude toward the use of this drug, I consider that the possible harm it may do outweighs the benefits it may possess.

Q. What are the indications for splenectomy in Gaucher's disease?

DR. STURGIS: I think two. One, the spleen may become so huge that it should be removed for mechanical reasons alone. Second, splenectomy is indicated if there is evidence of hypersplenism as shown by the enlarged spleen, the hyperplastic bone marrow, and a reduction in

the red blood cells, the neutrophils or the platelets, or all three in the circulating blood. In the few cases I have observed, in which a splenectomy was done, the results were good.

DR. STURGIS: Now, if we have nothing further, I think we will thank you for your very kind attention to this rather prolonged program and call it adjourned. Thank you.
(APPLAUSE)

EXAMINATION ANNOUNCED FOR MEDICAL OFFICER

The United States Civil Service Commission wishes to bring to your attention the new Medical Officer examination for filling the positions of rotating intern, \$2,800 a year, and resident in training in psychiatry and in neurology, \$3,400 to \$4,200, in St. Elizabeths Hospital in Washington, D. C.

For intern positions, applicants must be fourth-year students in an approved medical school. To qualify for the resident positions (psychiatry and neurology) applicants must be graduates of an approved medical school with the degree of doctor of medicine and must have successfully completed a year's internship, or now be serving such internship. No written test is required. The maximum age limit (waived for persons entitled to veteran preference) is 35 years.

Applications will be accepted by the Executive Secretary, Board of U. S. Civil Service Examiners, St. Elizabeths Hospital, Washington 20, D. C., until further notice, but qualified persons are urged to apply at once.

UNITED STATES CIVIL SERVICE COMMISSION

Component Medical Societies

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

The December meeting has just been held. It was truly the "president's" meeting. The stimulating panel on tuberculosis was probably the best in the series of panel programs inaugurated by President Fort. The attendance, two hundred and fifty plus, is a tribute to his leadership and understanding of what the members want.

The motion by Doctor Needle that each past-president, beginning with President Fort, be presented a key or other emblem in recognition of service was timely and appropriate. President-elect Gundry has a high mark to shoot at indeed.

The Postgraduate Courses Committee has its program in your hands. By the time its program goes to print one or more of the courses will have been finished, and the big question, whether the lecture halls will be adequate, will be answered.

Whether another closed-circuit telecast can be arranged is uncertain. The sponsors "... are convinced this type of program has very excellent possibilities for future development; in fact, we would be happy to consider having a part in future undertakings of this character.

"However the receipt of letters... assists our efforts to obtain appropriations necessary for such purposes, and we are quite hopeful that more will come in..."

The following officers, etc. were elected to serve for 1954 unless otherwise indicated:

President, L. P. Gundry; *First Vice-President*, A. R. Koontz; *Second Vice-President*, G. E. Ward; *Secretary*, E. F. Cotter; *Treasurer*, R. C. Kimberly; *Councillors*, L. L. Keown (1954), R. E. Lenhard (1954), Wetherbee Fort (1954), Samuel Wolman (1954-1955), H. E. Wilgis (1954-1955), D. J. Pessagno (1954-1955); *Delegates* (1954-1955), P. Artigiani, S. T. R. Revell, Jr., M. S. Sacks, J. W. Barnaby, Jr., F. W. Gluck, J. N. Classen, Gustav Highstein, J. C. Handelsman, M. P. Johnson,

Charlotte McCarthy, S. E. Muller, L. H. Pierce, F. K. Morris; *Alternate Delegates* (1954-1955), K. V. Kemp, M. L. Singewald, R. C. Abrams, P. C. Phelan, Jr., H. P. Biehl, E. H. Richardson, Jr., W. A. Anderson, V. C. Kelly, R. A. Reiter, J. D. Moores, J. F. Supplee III, K. K. Krulevitz, Abraham Genecin.

CAROLINE COUNTY MEDICAL SOCIETY

ROBERT H. WRIGHT, M.D.

Journal Representative

A meeting of the Caroline County Medical Society was held at the Tidewater Inn, Easton, December 19, 1953. Preparation was discussed for the January Meeting of the Upper Eastern Shore Medical Society, Brick Hotel, Denton.

The following were elected officers for the year 1954: *President*, H. Fletcher Silver, Goldsboro; *Vice-President*, Robert H. Wright, Greensboro; *Secretary-Treasurer*, Edwin G. Riley, Denton; *Delegate*, Charles H. Winnacott, Ridgely; *Alternate*, Harold B. Plummer, Preston and *Journal Representative*, Robert H. Wright, Greensboro.

CHARLES COUNTY MEDICAL SOCIETY

J. PARRAN JARBOE, M.D.

Secretary

At the meeting of the Charles County Medical Society the following officers were elected:

President, Richard F. Daly, La Plata; *Vice-President*, Harry R. Coburn, Bryantown; *Secretary-Treasurer*, J. Parran Jarboe, La Plata; *Delegate*, Arthur O. Wooddy, La Plata; *Alternate*, John H. Griffin, Hughesville; *Chief of Staff Physicians Memorial Hospital*, Edward J. Edelen. The officers were installed on Thursday, December 17, at the Hawthorne Country Club.

Meetings are held at the Jarwood Clinic in La Plata, Maryland on the second Thursday of every month at 8:30 p.m.

FREDERICK COUNTY MEDICAL SOCIETY

JESSE S. FIFER, M.D.

Journal Representative

The Frederick County Medical Society is an active one, in that it meets once a month except for July and August. Each meeting is preceded with cocktails and a dinner, followed by a business and scientific program. Meetings are well attended with an average of about three fifths of the membership. The following is our 1954 program:

January—Dr. John Whitridge—"Present Day Aspects of Toxemias of Pregnancy"

February—Dr. Lawson Wilkins—"Facts and Fallacies of Endocrinology"

March—Dr. Robert Furie—"Fluid Balance"

April—Dr. Francis A. Ellis—"Diagnosis and Treatment of Common Dermatoses"

May—Dr. R. K. Thompson—"Pain of the Head and Neck"

June—Dr. Charles Wainwright—"Arthritis"

September—Dr. Helen B. Taussig—"Selection of Patients for Surgery with Congenital Heart Condition"

October—Dr. Edwin H. Stewart, Jr.—"Tumors of the Head and Neck"

November—Annual Election of Officers and Business Meeting

December—Dr. Leonard Scherlis—"Recognition and Management of Cardiac Arrhythmia"

The following physicians have started practice in the County during 1953:

Bernard M. Davis, Jr.—General Practice—Frederick

Charles R. Williams—General Practice—Emmitsburg

Albert M. Powell, Jr.—Pediatrics—Frederick

Joseph Lerner—Neuro-psychiatry—Ijamsville

Henry Chase—General Practice—Frederick—Returned to practice November 4th.

We have lost two physicians, both moved to places in the west, who are:

Dr. William W. Orrison—to Oklahoma, and Dr. Hosea MacAdoo—to Arkansas.

HARFORD COUNTY MEDICAL SOCIETY

ROBERT BARTHEL, M.D.

Journal Representative

Minutes of meeting December 3, 1953

The following members were present: Doctors Barthel, Finney, Foley, Hatem, Hayman, Hodous, Horky, Hudson, Marek, McDonald, Norment, Rodman, Stewart, Stonesifer, Wolbert. *Guests:* Drs. Brendle, J. Dolce, Heuman

1. Veterans Medical Care—The secretary was directed to write to our senators and congressmen opposing care for non-service connected disabilities. (Motion by Finney, second by Hudson, passed unanimously.)
2. Formation of executive board to replace the board of censors, with authority to act for the society. This board is to consist of the president, vice-president, secretary-treasurer, and delegate.
3. Formation of Woman's Auxiliary—This request from the state society was referred to the Executive Board.
4. Dues for 1954—The secretary-treasurer will continue to collect county and state dues, *but not AMA dues.*
5. Maryland adoption law—The society is to request a hearing by the state legislative committee. Dr. Horky's statement is to be transmitted by the secretary. (Motion by Horky, second by Wolbert, passed unanimously.)
6. Insurance forms—A committee to consider a simplified form is to be appointed by the president. (Motion by Horky, second by Hatem, unanimously passed.)
7. **NEW MEMBERS:**

Brendle and Heuman were accepted for full membership. (Motion by Horky, second by Rodman, unanimously passed.)

8. **ELECTION OF OFFICERS:**

President, Robert Barthel, Forest Hill; *Vice-President*, Charles J. Foley, Havre de Grace; *Secretary-Treasurer*, Charles R. Hayman, Bel-Air; *Delegate*, Peter P. Rodman, Aberdeen; and *Alternate*, Richard Norment, III, Havre de Grace.

PRINCE GEORGE'S COUNTY MEDICAL SOCIETY

J. M. WARREN, M.D.

Journal Representative

Our annual election meeting was held December 1, and the following are our officers for the calendar year 1954: Dr. Julius Kauffman, 5102 Annapolis Road, Bladensburg, *President*; Dr. Benjamin Miller, 3824 34th Street, Mt. Rainier, *Vice-President*; Dr. William B. Hagan, 3303 Perry Street, Mt. Rainier, *Recording Secretary*; Dr. John S. Haught, 3303 Perry Street, Mt. Rainier, *Corresponding Secretary*; Dr. Albert Roth, 5507 Madison Street, Riverdale,

Treasurer. *Delegates* chosen to the Medical and Chirurgical Faculty were Dr. John Warren, 305 Prince George Street, Laurel, and Dr. Waldo B. Moyers, 3503 Perry Street, Mt. Rainier. *Alternate Delegates* selected were Dr. Samuel Sugar, 4300 Kaywood Drive, Mt. Rainier, and Dr. Wolcott Etienne, 4713 Berwyn Road, College Park. Dr. John T. Maloney, 2202 Cheverly Avenue, Cheverly, was selected to fill the one unexpired term of *Censor*.

The only other news forthcoming from this meeting was the report on our Annual Diabetes Detection Drive under the chairmanship of Dr. Samuel J. N. Sugar. Dr. Sugar reported a total of 1,521 tests had been performed from which 91 positive results had been recorded.

MILITARY PROMOTION REGULATIONS CHANGED

The AMA Washington Letter—No. 47

Some medical reserves will benefit from a change in Defense Department's directive on the revised doctor draft act. Under the first directive issued October 7, only experience prior to acceptance of a commission counted in determining whether the officer was entitled to a higher rank under the new law. The effect of the change is to credit all experience up to the time the officer goes on active duty. Under the previous interpretation, a number of men were in effect penalized in grade for the two or three years spent in the reserves prior to going on active duty. The new regulation means higher grades for some men when they are called up and promotions for others already on active duty.

MISCELLANY

The AMA Washington Letter, No. 50

Kenneth Williamson is taking over as the new director of the Washington Service Office of the American Hospital Association, succeeding Albert V. (Burt) Whitehall, who becomes executive director of the Washington (state) Hospital Service, with headquarters in Seattle. Mr. Williamson was assistant director of AHA for seven years before becoming executive vice president of Health Information Foundation. . . The new seal of AMA will be used in a Hill-Burton display to be shown starting in January in the Department of Health, Education and Welfare Building . . . Department of Health, Education, and Welfare reports 2,825 persons engaged as medical social workers in the United States, but says there are three jobs in this field for every qualified person.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

JAUNDICE AND DISEASES OF THE LIVER

LOUIS KRAUSE, M.D.

"For the king of Babylon stood at the parting of the way, at the head of the two ways, to use divination; he made his arrows bright, he consulted with images, he looked into the liver."—Ezekiel 21:21.

This verse refers to the ancient custom of basing the prognosis on inspecting the liver of a recently killed animal. Again, another instance of the importance of the liver we find constantly in our frequent use of the word, *melancholy*. This word originally came from the Greek meaning black bile, and was thought to be the cause of the feeling of depression. Here they thought the black bile came to the liver from the spleen since the average person at that time had an easily palpable spleen because of the presence of malaria, in all likelihood; and one could understand that they would feel a little on the depressed side with the presence of a chronic malaria.

It is obvious that they placed a great deal of importance on the liver even in ancient days, and rightly so. Today, we have, in spite of the 500 or more functions that have been documented for the liver, many unrecognized and unexplained functions and mechanisms. Without a doubt it is one of the most vital and most adaptive organs, and possesses the unusual ability of regenerating itself; this in such contrast to many other vital organs of the body. This fact is being recognized more and more today, and with every new advance in investigative technique, additional function and capacity of the liver are revealed.

The appended list of books broadly surveys the earliest and much of the latest information pertaining to the liver in health and in disease. The books are all available in the library.

BOOKS ON JAUNDICE

Bickel, A. Experimentelle Untersuchungen ueber die Pathogenese der Cholaemie. Wiesbaden, Bergmann, 1900.

Brule, M. Recherches sur les ictères. 3d ed., Paris, Masson, 1922.

Harley, G. Jaundice: its pathology and treatment. London, Walton and Maberly, 1863.

James, P. Dissertatio medica inauguralis, de ictero. Edinburgh, Balfour, 1787.

Legg, J. W. On the bile, jaundice and bilious diseases. New York, Appleton, 1880.

Lloyd, T. W. On the aetiology of acholuric family jaundice. Smethwick, B. T. Hill, Soho, 1940.

Norcom, J. An inaugural thesis on jaundice; containing observations on the liver and some of its diseases. Philadelphia, Carey, 1799.

Ravenscroft, J. Disputatio medica inauguralis de ictero. Edinburgh, Balfour, Auld, and Smellie, 1770.

Sermon, W. A friend to the sick: or, the honest English mans preservation. London, Edward Thomas, 1673.

Walters, W. Obstructive jaundice: physiologic and surgical aspects. Owatonna, Minnesota Journal-Chronicle, n.d.

BOOKS ON DISEASES OF THE LIVER

Acard, E.-A. Contribution à l'étude des cirrhoses pigmentaires. Paris, Steinheil, 1895. Thèse.

Annesley, J. Sketches of the most prevalent diseases of India. London, Highley, 1831.

Bassler, A. Diseases of the intestines including the liver, gall-bladder, pancreas and lower alimentary tract. 3d ed., Philadelphia, Davis, 1928.

Bellamy, T. Noctes Sarniae; de jecinoris morbis, vel tractatio simul morbidis urinae signis, authorê. Sarnia, G. Hamiltoni, 1850.

Boix, E. The liver of dyspeptics. New York, Putnam, 1897.

Boyce, F. F. The role of the liver in surgery. Springfield, Ill., Thomas, 1941.

Budd, G. On diseases of the liver. Philadelphia, Lea & Blanchard, 1846; also 2d American ed., 1853.

Cavina, C. Le indicazioni ed i metodi della resezione epatica. Bologna, Cappelli, 1952.

Cope, Z. Surgical aspects of dysentery including liver abscess. London, H. Frowde, 1920.

- Crawford, J. An essay on the nature, cause and cure of a disease incident to the liver. London, G. Kearsley, 1772.
- Cyr, J. Traité de l'affection calculeuse du foie. Paris, V. Delahaye, 1884.
- Drysdale, T. Tentamen medicum inaugurale varia de hepate proferens. Philadelphia, Dobson, 1794.
- Faithhorn, J. Facts and observations on liver complaints, and bilious disorders in general. 1st American ed., Philadelphia, Hickman, 1820; also 2nd American ed., 1822.
- Frerichs, F. T. Atlas of pathological anatomy illustrative of a clinical treatise on diseases of the liver. 2d corrected ed., Brunswick, Frederick Vieweg, 1862. 2 vols.
- Frerichs, F. T. A clinical treatise on diseases of the liver. London, The New Sydenham society, 1860-1861. 2 vols.
- Frerichs, F. T. von. Pathologisch-anatomischer Atlas zur Klinik der Leberkrankheiten. 2d enl. ed., Braunschweig, Vieweg, 1861.
- Genner, V. By-effects in salvarsan therapy and their prevention. Copenhagen, Levin & Munksgaard, 1936.
- Graham, E. A. and others. Diseases of the gall-bladder and bile ducts. Philadelphia, Lea, 1928.
- Habershon, S. O. The Lettsomian lectures delivered at the medical society of London, 1872, on the pathology and treatment of some diseases of the liver. London, Churchill, 1872.
- Hale-White, Sir W. Common affections of the liver. London, J. Nisbet, 1908.
- Hanot, V. La cirrhose hypertrophique avec ictère chronique. Paris, Rueff, 1892.
- Harley, G. The diseases of the liver. Philadelphia, Blakiston, 1883.
- Harrower, H. R. The hepatic principle, anabolin, detoxication by the liver and the control of functional hypertension. London, Baillière, 1927.
- Heyd, C. G. & others. The liver and its relation to chronic abdominal infection. St. Louis, Mosby, 1924.
- Johnson, J. A treatise on derangements of the liver, internal organs and nervous system. Philadelphia, Carey and Lea, 1825; also 1826.
- Kiernan, F. The anatomy and physiology of the liver. London, R. Taylor, 1833.
- Knox, R. Radiography in the examination of the liver, gall-bladder and bile ducts. St. Louis, Mosby, 1920.
- Körte, W. Beiträge zur Chirurgie der Gallenwege und der Leber. Berlin, Hirschwald, 1905.
- Lancereau, E. Traité des maladies du foie et du pancréas. Paris, Doin, 1899.
- Leblond, V. Diagnostic et traitement des abcès du foie. Paris, Baillière, 1893.
- Lereboullet, P. Les cirrhoses biliaires. Paris, Masson, 1902.
- Lichtman, S. S. Diseases of the liver, gall-bladder, and bile ducts. 2d ed., Philadelphia, Lea & Febiger, 1949.
- MacCallum, F. O. Infective hepatitis; studies in East Anglia during the period 1943-47. London, H. M. Stationery Off., 1951.
- McCausland, R. Dissertatio medica, inauguralis, de hepatitide. pro gradu doctoris. Edinburgh, Balfour, 1787.
- Malcolmson, J. G. Clinical remarks on some cases of liver abscess. Philadelphia, Haswell, Barrington, and Haswell, 1839.
- Mathews, S. Observations on hepatic diseases, incidental to Europeans in the East-Indies. London, Cadell, 1783.
- Merck and Company. Choline and methionine in the treatment of liver diseases. Rahway, N. J., Merck, 1946.
- Mukherji, S. K. Infantile cirrhosis of liver. Calcutta, Indian Medical Record Book Department, 1922.
- Murchison, C. On functional derangements of the liver. New York, William Wood, 1875; also 1879.
- Portal, A. Observations sur la nature et traitement des maladies du foie. Paris, Longchamps, 1813.
- Quincke, H. Die Krankheiten der Leber. 2. Auflage. Wien und Leipzig, Hölder, 1912.
- Rolleston, Sir H. D., bart., and McNee, J. W. Diseases of the liver, gall-bladder and bile ducts. 3d ed. London, Macmillan, 1929.
- Roose, R. Gout; its relations to diseases of the liver and kidneys. London, Lewis, 1894.
- Saunders, W. A treatise on the structure, economy and diseases of the liver. Boston, Pelham, 1797; also London, W. Phillips, 1803.
- Schwartz, E. Chirurgie du foie. Paris, Doin, 1901.
- Stock, T. Disputatio medica inauguralis de hepatitide. Edinburgh, Neill, 1802.
- Stone, A. D. A practical treatise on the diseases of

the stomach and of the digestion; including the history and treatment of those affections of the liver and digestive organs. London, Cadell and Davies, 1806.

Thomson, W. A practical treatise on diseases of the liver. Philadelphia, Barrington and Haswell, 1842.

Waterlow, J. C. Fatty liver disease in infants in the British West Indies. London, H. M. Stationery Office, 1948.

Weiss, S. Diseases of the liver, gall-bladder, ducts and pancreas; their diagnosis and treatment. New York, Hoeber, 1935.

REED INDICATES PHYSICIANS WILL BE EXCLUDED FROM OASI BILL

The AMA Washington Letter, No. 50

Chairman Daniel A. Reed (R., N. Y.) of the House Ways and Means Committee has indicated that in his opinion Congress should not force mandatory social security coverage on physicians and others who don't want it. Mr. Reed's committee will hold public hearings after the first of the year on the administration's proposal to extend Old Age and Survivors Insurance to about 10,500,000 more persons. The administration bill, introduced last August, would mandatorily take in physicians, dentists, farmers and virtually all other groups of self-employed.

In a statement outlining the committee's plans, however, Mr. Reed made clear that he is not in favor of compulsory coverage for groups that oppose coverage. He declared: "I believe that social security coverage should be extended to any group *which desires it.*" At its meeting earlier this month in St. Louis, the AMA's House of Delegates reaffirmed that the country's physicians *do not desire* social security.

Other committee objectives, as stated by Mr. Reed: Liberalize the present \$75 per month limit on earnings of OASI recipients, raise the level of minimum benefits and allow the social security tax to go up one half per cent as scheduled on January 1. Mr. Reed said that in the hearings "every interested group will be given an opportunity to testify."

DR. WILBUR ON MEDICAL TASK FORCE

The AMA Washington Letter—No. 47

Dr. Dwight L. Wilbur of San Francisco, clinical professor of medicine at Stanford University medical school, is the newest appointment to the medical task force of the Hoover Commission. A commission spokesman said his acceptance was received after release of the names of the remaining members last week. Dr. Wilbur is prominent in activities of the American Medical Association and his state medical society. He served in the Navy in World War II and has taken part in state and community civic work. Due to an error in biographical material furnished by the commission, Dr. Francis J. Braceland, a task force member, last week was incorrectly identified as dean of Loyola (Chicago) University School of Medicine. A former dean of Loyola, he is now full-time psychiatrist at the Institute of Living, Hartford, Connecticut.

Health Departments

HOME ACCIDENT PREVENTION STUDY

R. H. RILEY, M.D., Dr.P.H.*

Baltimore, Md.

During 1953 the Maryland State Department of Health has been preparing for the inauguration of a Home Accident Prevention program throughout the State. The planning stage is now completed and an epidemiological study of fatal home accidents was begun on January 1, 1954.

All physicians are aware of the remarkable achievements of preventive medicine during the past several decades. The application of its principles to communicable disease for example, has brought about an unbelievable improvement in mortality. Now that many of the infectious diseases have been brought under control, the present-day physician is brought face to face with the fact that in Maryland accidents are now the fourth leading cause of death and home accidents account for approximately one-third of this group. With these facts in mind, the plan as outlined by the State Health Department was approved by the House of Delegates of the Medical and Chirurgical Faculty on April 23, 1953.

This program was made possible by a financial grant to the State Health Department from the W. K. Kellogg Foundation of Battle Creek, Michigan. This Foundation in its desire to promote the health and education of mankind and to generally improve the level of living has made this grant available for a three year period to eight States, including Maryland.

Every effort is being made to cooperate with other organizations having an interest in this problem, such as the American Academy of Pediatrics accident prevention committee, American Red Cross, the Baltimore Safety Council, State Industrial Accident Commission, civic organizations, local youth organizations and 4H clubs as well as the local press, radio and television stations.

The procedure for obtaining the necessary infor-

mation required for this study will follow a prescribed pattern. A "Home Accident Fatality Report" partially reproduced in Figure 1, will be used by the local Health Department personnel in reporting information obtained from the interview with the informant.

As death certificates are received in the Division of Vital Records and Statistics of the Maryland State Health Department, they are processed and classified. Those certificates indicating an accidental death and not subject to normal investigation by local or State police departments, the Bureau of Motor Vehicles, the Industrial Accident Commission, the CAA or aviation commission, will be selected for investigation by the local Health Department.

The information on the Death Certificate will be transposed to the top portion of the "Home Accident Fatality Report." This form will be sent to the Bureau of Environmental Hygiene for review by the Home Accident Prevention unit in order to eliminate any inquiries which seem unjustifiable. The form would then be sent to the proper counties by the Bureau of Environmental Hygiene for completion.

In reviewing the information on the death certificate or top portion of this form, the County Health Officer will decide which person on his staff—public health nurse, sanitarian, or social worker—will be assigned the investigation. Where death was the result of a farm accident, a public non-motor-vehicle accident or home accident involving appliances or machinery, the sanitarian may be the best qualified person to make the investigation. The public health nurse would probably be asked to investigate most other home accidents. In the few counties having a social worker, he or she might be asked to do the investigation, particularly when that person has previously worked with the family and has established a good relationship with them.

In accordance with the agreement with the Medical and Chirurgical Faculty, each of these cases will be discussed with the family physician prior to calling on the home of the deceased person. It is quite possible that the family physician can pave

* Director—Maryland State Department of Health.

HOME ACCIDENT FATALITY REPORT
(Excerpt of Information to be Obtained by Interview)

INFORMANT: Please answer questions below.

16. What was the deceased doing when accident occurred?
17. a. Was an object involved in the accident? ☐ NO ☐ YES If YES, name the object.....
(For example, table, gun, stairs)
- b. If YES, was the object (check one) ☐ Worn ☐ New ☐ Defective ☐ In good condition ☐ Other (Explain).....
18. a. Was an agent such as fire, gas, water, poison, etc., involved in the accident? ☐ NO ☐ YES If YES, name the agent.....
- b. If fire was involved where did it start? What caused it?
- c. If fire was caused by heating equipment (for example, stove or furnace) what kind of fuel was being used?
- d. If poison was involved, what kind was it?
(For example, cooking gas, rat poison, barbiturate, kerosene).....
- e. If poison was swallowed, where did the deceased find it?
(For example, in medicine chest, on shelf in kitchen).....
19. Did poor lighting figure in this accident? ☐ NO ☐ YES ☐ DON'T KNOW
20. a. Was the deceased physically handicapped before this accident? ☐ NO ☐ YES ☐ DON'T KNOW
- b. If YES, what was the handicap? Did it lead to the accident? ☐ NO ☐ YES (Explain).....
21. Did another person's action figure in the accident? ☐ NO ☐ DON'T KNOW ☐ YES (Explain).....
22. Where in the home or outside of it did the accident occur? (For example, bedroom, hall, yard)
23. Was an adult with the deceased when the accident took place? ☐ NO ☐ YES ☐ DON'T KNOW
24. How many others were injured or killed in this accident? ... Injured ... Killed
25. In your opinion how could this accident have been prevented?
26. Did the deceased receive medical attention? ☐ NO ☐ YES If YES, how soon after the accident? ... Hours ... Days
27. Within 12 months before this accident, was deceased in any other accident which required medical attention, absence from work, or staying in bed? ☐ NO ☐ YES If YES, how many other accidents? ... DON'T KNOW
28. a. Was the deceased head of the family? ☐ NO ☐ YES b. Number of survivors who were dependent on the deceased's income.....
29. Describe in a few words how this accident took place.....

DATE	NAME OF PERSON COMPLETING THIS REPORT	RELATIONSHIP TO DECEASED (OR TITLE)
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ORIGINAL—STATE BUREAU OF VITAL STATISTICS

FIGURE 1

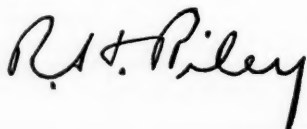
the way for the visit or be able to give much of the information required on the report form. If the name of the attending physician cannot be ascertained until after a contact is made with the family, the physician will be furnished with a report of the visit.

In addition to the family physician, the County Medical Examiner and local and State police departments may have information which will be of value to the Health Department in this investigation. Such data will serve to supplement the information supplied by the family and will be used if it has value to the study.

Inasmuch as the requests for investigation will be relatively few in each county, it is hoped that visits can be made within a few days after the report form is received. There are two very good reasons for not delaying the investigation: first, the account of the accident will be more accurate if the investigation is completed before certain facts become hazy or partially forgotten and, second, an interview when the family is already emotionally disturbed may create comparatively little additional disturbance while an interview at a later date, when the family has made certain emotional adjustments, may re-activate their grief and their feeling of responsibility. Here again the timing of the approach will be discussed with the family physician.

When the investigation has been completed by the County Health Department, the report form will be returned to the Home Accident Prevention unit of the Bureau of Environmental Hygiene for study and interpretation and will then be turned over to the Division of Vital Records and Statistics for tabulation.

The project which will consist of a comprehensive study and analysis of the underlying causes of all fatal home accidents as well as a limited epidemiological study of non-fatal home accidents will provide the necessary information for a preventive action program. It is intended that by pinpointing the problem and following through with an appealing educational program that many of these "needless" accidents can and will be prevented in the local communities of the State.



Director

BALTIMORE CITY HEALTH DEPARTMENT

Neonatal Home Nurse Visiting Program Modified

On December 10, 1953 the City Health Department wrote to each of the seventeen hospitals having maternity hospital licenses under the city ordinance advising them of changes in the Health Department public health nurse home visiting program for newborn babies. After careful study it was decided to limit the visiting to those mothers who would stand to benefit the most from such public health nursing visits. The new program became effective on January 1, 1954. The text of the letter sent on December 10 to chief obstetricians and chief pediatricians at each of the 17 hospitals, and to the hospital directors is as follows:

Dear Doctor:

At present, the resident mother of every infant born alive in this City is visited by a public health nurse approximately two weeks after birth of her child. With the passage of time and in view of our desire to conserve valuable nursing skills, we have found it necessary to study carefully the merits of visiting every mother regardless of need. Our impressions are that large segments of the white mother population make early provision for routine care of the newborn baby, and that the chief causes of death, premature birth, birth injury and congenital malformation, are conditions whose prevention, if any, lies in the prenatal period.

On the other hand, the mortality among Baltimore's colored infants, 40 deaths per 1,000 born alive, is about twice the rate for white babies. Analysis of this excess mortality indicates that death rates from preventable causes, i.e., pneumonia, malnutrition and accidental causes are higher among Negro infants than among the white infants. This excess is believed due to inadequate care in the home, to ignorance or to irresponsibility.

With these considerations in mind, we propose to modify our neonatal home visiting program as follows:

All babies in the following categories will be visited at home as soon as possible after birth:

1. Premature infants (below 2500 grams in birthweight).
2. Infants injured at birth.
3. Infants malformed at birth.
4. Negro infants.
5. Infants delivered at home.
6. Other babies at the discretion of the district health officer or the district supervising nurse or upon request of the attending physician at the hospital of delivery. Such requests should be made by telephone or mail to the Bureau of Public Health Nursing, Plaza 2-2000, Extension 404.

It is planned to introduce the new program on January 1, 1954. If you have any suggestions in regard to the above, we would welcome them. Please feel free to communicate with Dr. Janet Hardy, our Director of the Bureau of Child Hygiene, who will be glad to discuss them with you, Plaza 2-2000, Extension 324.

Sincerely yours,

Huntington Williams, M.D.

Commissioner of Health

FOUR GROUPS AT WORK WITHIN HOOVER COMMISSION MEDICAL TASK FORCE

The AMA Washington Letter, No. 51

To facilitate the gathering of information from government agencies and other sources, the Hoover Commission Medical Task Force has separated itself into four divisions. The findings will be "considered fully by the whole Task Force," according to the commission, before any conclusions are reached or any recommendations made. The makeup of the four teams:

Medical Services of the Armed Forces—Drs. E. D. Churchill (chairman), Michael DeBakey (co-chairman), Walter Martin, president-elect of the AMA, and Dwight L. Wilbur. Medical Services of the Veterans Administration—Drs. Basil C. MacLean (chairman), Francis J. Braceland, Evarts A. Graham, and Otto W. Brandhorst. Medical Services of the U. S. Public Health Service and Other Federal Services—Drs. Theodore Klumpp (chairman), Hugh Leavell (vice chairman), and Milton C. Winternitz. Overall Planning for Medical Services in Time of War—Drs. Paul Hawley (chairman), Alan Gregg (co-chairman) and James Roscoe Miller.

The commission also announced that Dr. James P. Dixon, formerly Philadelphia health officer and formerly acting director of the Clinical Center at Bethesda, Md., will be secretary of the Task Force and an assistant to Dr. Edwin L. Crosby, the research director.

STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, January 1-January 28, 1954

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOVELITIS, PARALYTIC	POLIOVELITIS, NON PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County.....	114	—	4	7	99	—	82	—	—	—	21	1	—	13	5	1	6	—	3
Anne Arundel.....	22	—	—	5	2	—	9	—	—	—	5	1	—	1	3	—	6	t-1	2
Howard.....	1	—	—	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Harford.....	19	—	1	17	3	—	55	—	—	—	10	—	—	5	2	—	—	—	1
Carroll.....	4	—	—	1	21	—	5	—	—	—	2	—	—	—	—	—	—	—	—
Frederick.....	9	—	—	3	2	—	1	—	—	—	12	—	—	1	2	—	1	—	2
Washington.....	3	—	—	10	1	—	10	—	—	—	9	—	—	—	4	—	1	—	1
Allegany.....	2	—	—	3	1	—	—	—	—	—	—	—	—	—	1	—	1	—	3
Garrett.....	—	—	—	2	1	—	—	—	—	—	—	—	—	—	1	—	1	—	—
Montgomery.....	27	—	1	1	2	—	36	—	—	—	8	—	—	—	10	—	1	—	2
Prince George's.....	13	—	—	1	1	—	3	—	—	—	4	—	—	1	5	—	1	—	5
Calvert.....	1	—	—	2	—	—	—	—	—	—	—	—	—	9	2	—	—	—	1
Charles.....	3	—	—	3	—	—	4	—	—	—	—	—	—	—	—	—	—	—	1
Saint Mary's.....	6	—	—	19	—	—	2	—	—	—	3	—	—	—	2	1	4	—	1
Cecil.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
Kent.....	1	—	—	3	—	—	11	—	—	—	6	—	—	4	—	1	—	—	—
Queen Anne's.....	1	—	—	—	—	—	3	—	—	—	—	—	—	—	1	—	—	—	2
Caroline.....	1	—	—	—	6	—	1	—	—	—	—	—	—	1	2	—	2	t-1	1
Talbot.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	—
Dorchester.....	1	—	—	—	1	—	—	—	—	—	—	—	—	—	4	—	8	—	—
Wicomico.....	7	—	4	—	52	1	—	—	—	—	1	—	—	—	5	1	11	t-2	—
Worcester.....	—	—	—	5	22	—	3	—	—	—	—	—	—	1	1	—	—	—	1
Somerset.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	3	—	—
Total Counties.....	235	0	10	84	214	1	225	0	0	0	81	2	0	36	52	4	47	—	27
Baltimore City.....	379	0	6	3	477	3	146	1	0	0	38	0	0	53	64	14	592	—	34
State																			
Jan. 1-28, 1954.....	614	0	16	87	691	4	371	1	0	0	119	2	0	89	116	18	639	—	61
Same period 1953.....	553	1	49	36	78	8	108	1	0	0	211	0	1	23	241	12	687	—	86
5-year median.....	375	6	27	—	540	7	114	2	—	0	129	1	4	52	181	25	540	—	60
Cumulative totals																			
State																			
Year 1954 to date.....	614	0	16	87	691	4	371	1	0	0	119	2	0	89	116	18	639	—	61
Same period 1953.....	553	1	49	36	78	8	108	1	0	0	211	0	1	23	241	12	687	—	86
5-year median.....	375	6	27	—	540	7	114	2	—	0	129	1	4	52	181	25	540	—	60

t = tularemia.



Blue Cross - Blue Shield



SUBSCRIBER SERVICE

R. H. DABNEY*

Saratoga 7-6313 is a direct line to service. Through its trunks and its extensions, our subscribers voice their problems, their questions and, not infrequently, their opinions. Few telephone numbers mean as much to so many people, and none is any more sensitive or any more responsive to the human traffic moving back and forth over its circuits.

Subscribers under Blue Cross and Blue Shield not only receive service benefits, but just as important, the benefits of service. To listen to their voices is to grasp the full meaning of this distinction. A young housewife calling long-distance from Hagerstown asks to include her new-born child under a family membership. On another extension, a steelworker employed at a local shipyard requests a transfer from Pittsburgh to Baltimore. Sometimes at the rate of 5,000 calls a day, they ask—and they receive.

The volume is great. Year after year, as enrollment swings upward, the people who know the answers (our employees) do more and more for the people who ask the questions (our subscribers). Although too high a utilization rate in hospital-medical-surgical benefits could virtually cripple Blue Cross and Blue Shield, the incidence rate in service is never an abuse.

For us, service is not just a catchword, or a fancy sales slogan. Helping our subscribers—The Blue Cross and the Blue Shield public—is actually our job. Through our help, our subscribers always learn something more about their membership and, in learning, benefit themselves by a more effective use of the program. If, in our public relations for the program, we talk most about service benefits, it is not because we neglect, in our human relations with subscribers, to provide for service *and* benefits.

Subscription agreements, as well as descriptive brochures, define the benefits which the 40 member hospitals sponsoring Blue Cross and the 1,700 par-

ticipating physicians sponsoring Blue Shield deliver to our subscribers. In this primary function, our hospital-sponsors and our physician-sponsors insist upon a direct and confidential relationship with their patients. No other relationship would be acceptable to the medical profession or to the American people.

In service, just as with benefits, the shortest distance between two points is a straight line. This is axiomatic. Just as the hospitals and the doctors make sick people well through individual treatment, so Blue Cross and Blue Shield strive to communicate face-to-face with each and every subscriber. Once this precious personal contact is disturbed, our efforts become ineffective and unproductive. It is almost proverbial to say that to do our best we must be as close to our subscribers as our facilities will permit.

We are equipped in mind and in matter for our obligation in human relations. What is more important, we believe that our natural willingness to serve is, in the final analysis, our great strength in competition with commercial carriers in the health field. Whatever the problems and whatever the questions, we can depend upon our employees to find the answers. Each operational unit at Blue Cross and Blue Shield is, in effect, a service unit, and each employee, from receptionist to switchboard operator, is trained to direct a subscriber with a question to a department with an answer.

Of all the Blue Cross and Blue Shield Departments, "Subscriber Service" is closest to our public. At least five telephone clerks, assisted by specialists in general office procedure, screen the calls from subscribers. If a question is unusually complicated, the telephone clerks either funnel the call to another answer-center or, in the absence of an immediate decision, refer the call to correspondence clerks who gather necessary information and prepare detailed replies. Five full-time interviewers in another section of the department talk to the subscribers who come into our offices.

Despite our efforts, some subscribers bypass the Plan when they actually use hospital-medical-surgical benefits. Because they do not understand our

* Director, Maryland Hospital Service, Inc., Maryland Medical Service, Inc.

dual purpose, they think that with each admission and with each diagnosis the hospitals and the physicians should answer "Twenty Questions" about Blue Cross and Blue Shield. They forget, for a moment, that hospitals are crowded and that doctors are busy. Under the emotional impact of an overwhelming illness, they do not use the easy access to the Plan office.

If they stopped to think, they would realize that prepayment (the basic principle which sustains Blue Cross and Blue Shield) is a two-way street. In one direction, patients receive service benefits. In the other direction, subscribers receive beneficial services. But if, when subscribers become patients,

they go in only one direction—if they refer more than just their symptoms to the doctors and the hospitals—an unfortunate traffic jam can result.

Before our enrollment gets much larger, we must mark the lanes to an effective and productive use of Blue Cross and Blue Shield so clearly that subscribers will not impose upon our sponsors with general inquiries not related to actual patient care. To achieve the best results, we who administer Blue Cross and Blue Shield must depend upon the doctors and the hospitals, as much as upon our own resources, to bring subscribers home to their plan—through the direct line to service which awaits their use.

MANION COMMISSION PANEL STARTS SURVEY OF U.S. GRANTS

The AMA Washington Letter—No. 48

A panel of consultants to the Manion Commission has started a national sampling survey to "determine the composite impact of all federal aid programs in the state and local fields where the service is rendered." It will look into all programs where both federal and state or local funds are used, including vocational rehabilitation, grants for crippled child work and for the disabled and several other activities of medical interest.

On the basis of findings of the survey, and information from other sources, the commission expects to recommend changes designed to limit federal participation and stimulate more activity by the states and local communities.

The survey will involve only four or five states in five general areas of the country. According to the commission, it is the first time this technique has been applied to the problems of federal-state relationships.

Members of the commission are Arthur E. Buck, West Norwalk, Conn., an authority on public budgeting; Phillip Cornick (Ph.D.), Chicago, a governmental research consultant; Edward Litchfield, Ithaca, N. Y., dean of the School of Business and Public Administration, Cornell University; Herbert Simpson, (Ph.D.) Evanston, professor at Institute for Economic Research, Northwestern University.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. CHARLES H. WILLIAMS, *Auxiliary Editor*

SEMI-ANNUAL MEETING, 1953, BETHESDA, MD.

President's Message

MRS. JOHN G. BALL

I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals.

This is the pledge we say at Auxiliary meetings and which is always most impressive at the national conventions. There, we hear voices from every state in the union, Hawaii and Alaska pledging themselves to the work of the Auxiliary.

Now just what is that work? Those high ideals? Our constitution states our objects to be: (1) Through our members to extend the aims of the medical profession to all organizations which look to the advancement of health and health education; (2) To fulfill such functions as may be desired from time to time by the Medical and Chirurgical Faculty of the State of Maryland; (3) To promote acquaintanceship among physicians' families that fellowship may increase and at all times to stimulate a feeling of local cooperation. Each of these objects is important and vital to the medical profession in Maryland. No one member or one county can do this alone. Accomplishment of our objects depends on the willingness of each individual member to do her part.

At the National Convention in New York, June 1-5, 1953, we were shocked to learn that Maryland is at the very bottom of the list for Woman's Auxiliary Membership Percentage of the American Medical Association membership, that percentage being 23.5%. Now is the time for us, each and every one of us, to get busy and find those friends of ours in unorganized counties, visit them, talk with them about the Auxiliary, tell them our objects, the work we have been doing, and how rewarding the con-

tacts and friendships we make, become. Your Organization Chairman, Mrs. Albert E. Goldstein, and your President will be happy to visit or have any suggestions you may have. The most successful membership and organization work has just one secret—"personal contact and interest." At the Presidents' Conference following the New York meeting, Mrs. Leo J. Schaefer, our National President, gave us this theme: "Together we progress." Let us work together for progress in membership and organization.

As we strive for more members and more organized counties, let us not forget the work we have already started that needs our continuing support. In New York, we were proud to report our successful Future Nurses Convention held in Baltimore on May 12, 1953, when nearly 400 enthusiastic high school girls heard speakers on all phases of nursing, saw American Medical Association nursing films, and heard student nurses, in uniform, from 14 hospitals speak. All our organized counties have nursing scholarships. A Nurse Recruitment film is being made of the nursing schools in Maryland and will be ready for use this winter. Some of the high schools have Future Nurse Clubs which interest and teach the girls about nursing. More county Auxiliaries should sponsor these groups. In these ways we are meeting the challenge of the shortage of nurses which the American Medical Association has requested of us.

There are other continuing challenges for us; one of the greatest is in the field of Public Relations or "Public Responsibility" as one state has so aptly paraphrased it. Each doctor's wife needs to be informed and keep informed so she may be prepared to talk with the lay persons she meets daily, when questions are asked. Have you noticed that you can scarcely pick up a magazine but what there is some challenging article related to medicine, physicians, medical fees, malpractice suits, doctor shortage, emergency service and a host of other questions,

vital to us as physicians' wives and Auxiliary members. As individuals, we participate in many activities of educational, civic and religious organizations. All of these contacts are most important and should be extended. Public service is the ultimate goal of public relations. How best may we serve our communities in the field of health? The American Medical Association has been increasing its public service by developing voluntary health insurance, doctor placement service, emergency call systems, exposing quacks and continuing to look for a solution to the problem of the chronically ill, ageing, and mentally ill. Above all, we must continue to maintain the prestige and esteem of the medical profession in the eyes of the public.

Civil Defense needs our continuing greater interest and effort. Much of the organizational work has been completed so we should be able to see definite progress this year. Each one should find the place she may best help in her local organization.

Last year the American Medical Association asked the Auxiliary to help the American Medical Education Foundation with the problem of raising money for the medical schools of the country, most of which have large deficits. The National Auxiliary gave \$10,000 to the Foundation at the New York meeting. Efforts must be continued to meet the goal of \$2,000,000 for this year. Let us continue to urge all physicians to subscribe to their medical schools through the American Medical Education Foundation. All such money given by physicians through the Foundation is matched by funds subscribed by private industry. Speak to your husband about this.

To help us in all these important tasks, we have the "Bulletin of the Woman's Auxiliary to the American Medical Association." Each National Chairman through her contacts throughout the states and through the states to the counties has a wealth of information and help to offer each of us. The only way we can avail ourselves of this help is to subscribe to the "Bulletin." Until we all start reading and using the material presented to us, we are not beginning to do our job. If you do not subscribe, please do. The Bulletin Chairman, Mrs. S. Jack Sugar, 6709 41st Avenue, University Park, Maryland, will be happy to take your subscription for \$1.00.

Another object of the Auxiliary is being fulfilled with this Semi-Annual Meeting. The Auxiliary

helped with the planning and entertainment of this meeting as requested by the Medical and Chirurgical Faculty.

WAYS AND MEANS

After the Ball is Over

MRS. E. ELLSWORTH COOK*

The first Annual Medical and Chirurgical Faculty Ball is now just a memory but it was the wonderful climax to many months of planning, meetings, phone calls, and rehearsals. A year ago last summer when Mrs. Albert E. Goldstein, the President of the Woman's Auxiliary to the Baltimore City Medical Society asked me to be the Chairman of the Ways and Means Committee, I decided that a spring dance would be the most enjoyable way to raise funds. But, it always takes money to make money and the treasurer was unable to pay the many expenses connected with so costly an undertaking. Therefore, an affair had to be held in the fall to even consider plans for a dance. The Dessert Luncheon, Fashion Show, and Card Party in November netted us many new friends and slightly over five hundred dollars. Now, we were ready!

At the end of November, a meeting was held of the Ways and Means Committee members with their husbands, and the three advisors from Baltimore City Medical Society along with their wives to ask for the cooperation and advice of the organized medical profession. They were in favor of the idea and agreed to ask permission of the City and State Society, which was forthcoming. Dr. Edwin H. Stewart, Jr. deserves the credit for the idea to make the Ball an annual affair in conjunction with the Annual Meeting of the Faculty. Monday evening was chosen to enable as many county members as possible to attend. Everyone was in favor of having the dance at the Faculty Building to save expenses but the accommodations were too limited and the date conflicted with the scientific sessions, hence the Alcazar was chosen.

One of the biggest headaches and later heartaches was the question of the Federal Amusement tax of 20%. None of us felt we should be compelled to collect and pay that tax. Certainly, none of the money

* Chairman, Ways and Means Committee.

we made was for personal use; it was going to be used for educational and charitable purposes. I called the Baltimore office of the United States Amusement Tax Division and was told the Auxiliary did not fulfill the requirements for tax exemption. However, it was suggested that I write to Washington and send along a copy of the Constitution and By-Laws and a yearly Treasurer's report. Anxious months passed and finally word was received the Auxiliary would be required to pay the tax.

The "motif" for our Ball came about by a spontaneous brain-storm between Mrs. Irving J. Taylor and myself. During one of our innumerable phone calls, I suggested a Spanish side-walk café setting for the supper room in the Faculty Building. (This was before the decision to use the Alcazar.) I felt that those guests having to be seated downstairs should be compensated with an attractive atmosphere. Mrs. Taylor was in agreement but said that sidewalk cafés reminded her more of France than the Spanish countries. That was it! Our theme! We would invite the guests to spend "An Evening in Paris." The rest was easy and in the following few minutes we planned the "Folies Baregere" with the can-can girls and boys, the Apache dancers (Will anyone ever forget the hit made?), the lovely songs of Mrs. Robert Goldstein, Dr. Hymen Rubin and Mrs. John J. Erwin, the Merry Widow Waltzers, and the lavish showing of fashions from Schleisner and Company. If I say the "Folies" were planned in a short time, I do not mean to give the impression that it came into actuality that easy. From that day until the end of April, Mrs. Taylor's time and talents were wholeheartedly donated to produce an entertainment worthy of the best ability of every member of the cast. She wrote new words to two songs, along with the dialogue of the able Master of Ceremonies, Dr. Louis J. Kolodner. She devised the choreography of the can-can and the waltz and taught and rehearsed the dancers and singers. Lastly, the main burden of casting the show was hers. Everyone who enjoyed the "Folies" owes her a tremendous debt of gratitude.

The biggest problem facing me as Chairman was to find able members who were willing to head committees. As far as possible, I had hoped to have a program with a patron list and advertisers in order to cover the expenses of several thousand dollars without using funds from the Treasury. If you can

do this a large balance is not necessary in order to plan an undertaking of this kind. Our program, due to the hard work of the Chairman, Mrs. John B. DeHoff, and her Patron Chairman, Mrs. J. Arthur York, and Special Contributions Chairman, Mrs. Edwin H. Stewart, Jr., netted us well over one thousand dollars. We asked for special contributions from those business firms which we felt would directly benefit from advertising to the medical profession such as drug stores, medical supply houses, and pharmaceutical firms, etc.

Another idea I had for added proceeds was to combine a bazaar with our Ball. In keeping with the French motif the bazaar area was called the "Rue de la Paix" and French perfume, jewelry, fashion accessories, cosmetics, paintings, cakes and candy, Nurse dolls, etc., were offered for sale. Some of the articles sold very well (the Nurse dolls) but for the most part the sales were disappointing and not worth all the trouble involved. Personally, I felt that the majority of the guests at a Ball would rather enjoy themselves dancing and being among friends than in buying merchandise.

The distribution of tickets was a major accomplishment and ably handled by Mrs. Richard M. Garrett and her committee. Each physician member of the Faculty was invited to be a patron by a personal letter and two tickets were enclosed. It was felt that even though many could not attend, they believed in what we were trying to do and wanted to contribute. Tickets were also available at our Auxiliary meetings and at the door of the Alcazar for the convenience of those guests who wanted extras at the last minute.

Extensive publicity is a *MUST*! The newspapers of Baltimore were contacted as far as possible in advance of the April date to insure full coverage. Each paper promised one picture. Mrs. J. Carlton Wich, the Chairman, felt that publicity pictures should be of different committees and performers in the show. Altogether, there were eight or nine columns in the papers and several pictures. I was able to obtain permission from three different television stations to include acts from the "Folies" on three of their widely viewed programs. Those of us who appeared on TV got a lot of fun out of it and found it is not as frightening as it seems. The Maryland Medical Journal was our best source of publicity to try to convince the doctors and their families they

should not miss our Ball. Numerous articles and a picture were printed. I am truly grateful for the help of Mrs. George H. Yeager, the Auxiliary Journal Editor who was always willing to take time out of her very busy schedule to assist me in composing the various letters I was called upon to write. I sent a letter to the French Ambassador in Washington asking him to be our Guest of Honor and he was quite distressed that he couldn't accept the invitation. The Mayor, Governor, and two Senators were also invited but could not attend.

Didn't the Alcazar look beautiful? Those of you who were present, have you ever seen it more lavishly decorated? Mrs. Raymond Markley, Jr. and her committee worked all day trying to transpose it into an atmosphere of gay Pareé. The results looked magnificent, even down to the tiny Eiffel Tower table decorations. I knew the evening would be a success the minute I saw the Ballroom. No one could help having fun in that setting.

I have written this article to help other Auxiliaries plan an affair such as ours and have only briefly touched on the detailing of the work involved. We were able to cut expenses by several ways such as being fortunate enough to purchase the set-ups at less than cost and sell them for profit. Also we hired a non-union orchestra and were pleased to be able to save over one hundred dollars on their fee. Many

important committees I have had to omit, such as the refreshments, flowers, raffle, etc., but they all contributed to our final net figure of slightly better than twenty-two hundred dollars profit. We did not give our Ball primarily for monetary proceeds but rather to have a pleasant evening renewing acquaintances with old friends and colleagues. But we are proud to report the distribution of the profits as follows:

\$500.00 to the Building Fund of the Medical and Chirurgical Faculty of Maryland

\$500.00 to the American Medical Education Foundation

\$500.00 to the Woman's Auxiliary of the Maryland Medical and Chirurgical Faculty

\$300.00 for a full Nursing Scholarship

\$100.00 for the Nurse Recruitment Film the Woman's Auxiliary to the Baltimore City Medical Society is sponsoring.

The plan for next spring's Medical and Chirurgical Ball is already taking shape in a little corner of my mind and I hope it will be even better than last year's. I need everyone who can to volunteer to serve on the committees and talented medics and their families for the show. Only with the whole-hearted support of the Auxiliary wives and their physician husbands throughout Maryland can an evening of this type be eminently successful.

Reports

JOINT ANESTHESIA STUDY COMMITTEE OF THE

Baltimore City Medical Society and the Baltimore City Health Department

OTTO C. PHILLIPS, M.D.*

Through the joint efforts of Dr. Wetherbee Fort, President, the Baltimore City Medical Society and Dr. Huntington Williams, Commissioner of Health, The City of Baltimore, The Joint Anesthesia Study Committee was appointed on April 20, 1953. The present membership of the Committee is as follows:

1. Dr. Robert Dodd, Professor of Anesthesiology, The University of Maryland School of Medicine.
2. Dr. Donald Proctor, Professor of Anesthesiology, The Johns Hopkins Medical School.
3. Dr. Edward I. Lederman, Chairman of the Anesthesiology Section of the Baltimore City Medical Society.
4. Dr. Russell Nelson, Director, The Johns Hopkins Hospital, President of the Baltimore Hospital Conference.
5. Dr. Matthew Taback, Director, Statistical Section, The Baltimore City Health Department, and Secretary of the Committee.
6. Dr. Russell S. Fisher, Chief Medical Examiner of Maryland.
7. Dr. John C. Krantz, Professor of Pharmacology, The University of Maryland School of Medicine.
8. Dr. Joseph Leo Lilienthal, Jr., Associate Professor of Medicine, The Johns Hopkins Medical School.
9. Dr. Huntington Williams, Commissioner of Health of Baltimore.

* Chairman, The Joint Anesthesia Study Committee.

10. Dr. Cless Y. Fordyce.
11. Dr. Frank Brady.
12. Dr. Otto C. Phillips, *Chairman*.

The Committee held its first meeting on April 25, 1953. As a result of this meeting, and of subsequent sub-committee meetings, the following plans were agreed upon:

1. **OBJECTIVE OF COMMITTEE.** The purpose of the Committee is to discuss every death in this City that occurs the day of or the day after operation for the purpose of uncovering repetitive errors and for the dissemination of information on errors. In no case will the Committee attempt to identify any individual or hospital.
2. **REPORTING OF CASES.** Cases referred consist of *all* deaths which meet the above specifications. The flow of information is initiated through the Statistical Section of the Health Department by a study of the data appearing on the death record. A study form is sent the hospital and a case number assigned the patient. Upon the return of this study form to the Committee, the only link between the case number and the hospital is in the files of the Health Department.
3. **MEETINGS.** Monthly meetings will be held on the third Wednesday of each month at 8:30 P.M. at 1211 Cathedral Street. Protocols are prepared by a sub-committee and presented to the group at large for discussion.

Requests for case studies began on August 1, 1953. As of November 1st 48 requests had been submitted with 35 returns, which is a gratifyingly high degree of response and cooperation. The first discussion meeting was held in October. They have been and will continue to be held regularly.

COMING MEETINGS

THE EYES OF THE WORKER

OCCUPATIONAL VISION CONFERENCE,
1211 CATHEDRAL ST.

Wednesday and Thursday, March 3 and 4, 1954.

In an effort to show how production, safety and employees' health and satisfaction can all be increased by recognition of the factors that affect his ability to see well on the job, the University of Maryland is planning an Occupational Vision Conference to be held March 3 and 4, 1954, at the Medical and Chirurgical Faculty Building at 1211 Cathedral Street, Baltimore, Maryland.

The Ophthalmological Section of the Baltimore City Medical Society has found this project to be of such a nature that we have become one of the participating agencies sponsoring this program. The conference will attempt to point out the advantages to be gained from occupational vision programs by means of talks, panel discussions and exhibits. It is expected to attract attendance from representatives of industry and commerce as well as ophthalmologists, optometrists and illuminating engineers. It will be of special interest to management representatives of business and industry, heads of medical departments, efficiency experts, personnel managers and safety directors.

It is rather interesting to note that one out of every three employees is visually unqualified for satisfactory performance in his job. This has been proven true by many hundreds of thousands of visual performance tests. The employee who has been indoctrinated in an occupational vision program will carry this information into his day to day living. In traffic accidents alone, studies have found that visual deficiencies are at the top of the list of physical ailments as factors in accidents involving drivers who report repeated number of accidents.

This type of program has a dollar value to industry as well as a value for the recipient that cannot be counted in dollars and cents. Programs have been established and have proved their worth in many business organizations. In one organization, it was shown that 57% of the people with defective vision are poor producers. Such a program

reduced accident costs in one department by 40% and in one job reduced rejected work by 50%. The programs are geared to cover all types of operations, including the period of training. In one company, training time was cut in half and the absenteeism was reduced by 62%. The need for an occupational vision program exists in every company, big and small.

As an employee grows older, the more valuable he becomes, due to his experience and "know-how." By the same token, the older the employee, the more need he has for an occupational vision program. The U. S. Public Health Service has made studies which definitely show that the entire population is subject to a gradual reduction of visual adaptability with age increase.

PAN AMERICAN CONGRESS OF OPHTHALMOLOGY IN SÃO PAULO, BRAZIL

Plans are well advanced for the Third Interim Congress of the Pan American Association of Ophthalmology, which is to be held in São Paulo, Brazil, June 17-21, 1954.

Dr. Moacyr E. Alvaro, São Paulo, president of the Association, has announced that the scientific sessions of the Congress will be devoted to presentation of recent advances in treatment of diseases of the eye and in the prevention of blindness.

Meeting concurrently in São Paulo will be the Eighth Brazilian Congress of Ophthalmology and the Nineteenth International Congress of Otorhino-Ophthalmology.

Simultaneous translations in English, Spanish and Portuguese will be provided for the sessions of the Interim Congress, to enable those present to hear the scientific papers and other proceedings in the languages they know best.

Many social events have been planned, including opportunities to enjoy typical Brazilian experiences, which will be of particular interest because São Paulo is celebrating its fourth centennial this year. For example, there will be a presentation of Brazilian dances and a visit to a coffee plantation. Physicians

who register for the Congress before the end of February 1954 will receive invitations to dinner parties in the homes of Brazilian physicians.

There will be a registration fee of \$10, which will cover many of the events, including attendance at the other two congresses. Attendance is not restricted to members of the Association, according to Dr. Alvaro.

The Pan American Association of Ophthalmology was founded in 1939 through the initiative of the late Dr. Harry S. Gradle of Chicago and Dr. Alvaro. The world was then at war, and it was evident that international meetings would be suspended indefinitely. With the sponsorship of the American Academy of Ophthalmology and Otolaryngology,

a committee consisting of Dr. Gradle, Dr. Alvaro and Dr. Conrad Berens of New York organized the first congress, which was held in Cleveland in 1940. The second was held in Montevideo, Uruguay, in 1945 after the close of the war; the third in Havana, Cuba, in 1948, and the fourth in Mexico City in 1952.

As interest increased, the interval of four years between congresses appeared too great, and it was decided that interim meetings would be advantageous. The first of these was held in Miami Beach, Florida, in March 1950, in conjunction with the annual meeting of the National Society for the Prevention of Blindness (U.S.A.). The second took place on a Caribbean cruise in January 1953.

SECTION ON DISEASES OF THE CHEST

A. MURRAY FISHER, M.D., *Chairman*

EDMUND G. BEACHAM, M.D., *Secretary*

Wednesday, March 3, 1954, 8:00 p.m.

1211 Cathedral Street

Treatment of Pulmonary Emphysema. DOUGLAS G. CARROLL, M.D., Assistant Professor of Medicine, The Johns Hopkins University School of Medicine, and Assistant Chief of Medicine, Baltimore City Hospitals. (Illustrated.)

OTOLARYNGOLOGICAL SECTION

C. CARLETON DOUGLASS, M.D., *Chairman*

ALBERT STEINER, M.D., *Secretary*

JOINT MEETING WITH OTOLARYNGOLOGICAL SECTION OF THE DISTRICT OF COLUMBIA MEDICAL SOCIETY

Tuesday, March 9, 1954

Johns Hopkins Club, Homewood Campus

Cocktails 6:00 p.m. Dinner 6:30 p.m.

My Experiences with a Non-Operative Treatment of Chronic Sinusitis and Nasal Polyps. Samuel J. Crowe, Emeritus Professor, Otolaryngology, The Johns Hopkins University School of Medicine.

Discussion by Walter L. Winkenwerder, M.D., Assistant Professor of Medicine, The Johns Hopkins University School of Medicine.

CANCER SECTION

EDWIN H. STEWART, JR., M.D., *Chairman*

ARTHUR G. SIWINSKI, M.D., *Secretary*

Wednesday, March 10, 1954

National Institutes of Health, Bethesda

Notice will be sent.

MARYLAND PSYCHIATRIC SOCIETY

1211 Cathedral Street, Baltimore

LEONARD J. GALLANT, M.D., *Secretary**Thursday, March 11, 1954, 8:30 p.m.*

Observations on the Role of Depressive Mechanisms in Certain Patients with Disseminated Lupus. ROBERT McCLARY, M.D., Instructor in Psychiatry, The Johns Hopkins University.

Discussants: MAURICE H. GREENHILL, M.D., Associate Professor of Psychiatry, University of Maryland. LAWRENCE E. SHULMAN, M.D., Assistant in Medicine, The Johns Hopkins University.

RADIOLOGICAL SECTIONDAVID N. GOULD, M.D., *Chairman*H. LEONARD WARRES, M.D., *Secretary*

The Radiological Section of the Baltimore City Medical Society does not plan on holding a meeting in March since the Eastern Conference of Radiologists will be holding their meeting on the twelfth and thirteenth of March at the Statler Hotel in Washington, D. C.

ANESTHESIA STUDY COMMITTEE

1211 Cathedral Street, Baltimore

Wednesday, March 17, 1954, 8:30 p.m.

Joint Anesthesia Study Committee of the Baltimore City Medical Society and the Baltimore City Health Department.

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

Sponsored by the Maryland Division of the American Cancer Society and the Medical and Surgical Faculty.

RICHARD W. TELINDE, M.D., *Chairman*BEVERLEY C. COMPTON, M.D., *Secretary*

1211 Cathedral Street, Baltimore

*Thursday, March 18, 1954, 5:00 to 6:00 p.m.***BALTIMORE CITY MEDICAL SOCIETY**LEWIS P. GUNDRY, M.D., *President*AMOS R. KOONTZ, M.D., *First Vice President*EDWARD F. COTTER, M.D., *Secretary*ROBERT C. KIMBERLY, M.D., *Treasurer*GRANT E. WARD, M.D., *Second Vice-President**Friday, March 19, 1954, 8:30 p.m.**Osler Hall, 1211 Cathedral Street***PANEL DISCUSSION: THE USES AND ABUSES OF ACTH AND CORTISONE**

A. McGehee Harvey, M.D., *Moderator*, Professor of Medicine and Director of the Department of Medicine, The John Hopkins University School of Medicine.

Participants:

Joseph L. Hollander, M.D., Assistant Professor of Clinical Medicine and Director of the Department of Medicine, University of Pennsylvania School of Medicine, and Assistant Professor of Internal Medicine, The Medico-Chirurgical College, Postgraduate School of Medicine, University of Pennsylvania, Philadelphia, Pennsylvania.

Lawrence E. Shulman, M.D., Assistant in Medicine, The Johns Hopkins University School of Medicine.

Alan C. Woods, M.D., Professor of Ophthalmology and Director of the Department of Ophthalmology, The Johns Hopkins University School of Medicine.

Leslie N. Gay, M.D., Associate Professor of Medicine, The Johns Hopkins University School of Medicine.

Raymond C. V. Robinson, M.D., Instructor in Medicine and Assistant in Dermatology, The Johns Hopkins University School of Medicine.

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Question Period

DERMATOLOGY SECTION

RAYMOND C. V. ROBINSON, M.D., *Chairman* WILLIAM R. BUNDICK, M.D., *Secretary*

Monday, March 22, 1954, 8:30 p.m.

1211 Cathedral Street, Baltimore

1. Present Status of Local Hydrocortisone Therapy, by H. M. Robinson, Jr., M.D. and R. C. V. Robinson, M.D.

Discussion opened by Eugene Bereston, M.D.

2. Uses of High Frequency Vacuum Machines for Hypertrichosis, by F. A. Ellis, M.D.

Discussion opened by Albert Schapiro, M.D.

MATERNAL MORTALITY COMMITTEE

1211 Cathedral Street, Baltimore

Thursday, March 25, 1954, 4:00 to 5:00 p.m.

Joint Committee on Maternal Mortality of the Baltimore City Medical Society and the Baltimore City Health Department.

DR. JACK W. KOLSON MEMORIAL LECTURE (FOURTH RENEWAL)

Sponsored by House Staff of Sinai Hospital

Thursday, March 25, 1954, 8:30 p.m.

Hurd Hall, The Johns Hopkins Hospital

Approaches to Chemotherapy of Cancer. SIDNEY FARBER, M.D., Professor of Pathology, Harvard University School of Medicine, Boston, Massachusetts.

MARYLAND ACADEMY OF GENERAL PRACTICE

The date for the spring meeting of the Maryland Academy of General Practice in Hagerstown, is Thursday, May 13, 1954.

Dr. Robert P. Conrad, Hagerstown, has been appointed Chairman of the local Committee on Arrangements.

If there is any change in the date of the meeting there will be a notice to this effect.

William T. Layman, M.D., Secretary
Maryland Academy of General Practice

A.M.A. NEWS RELEASE—WASHINGTON OFFICE

Washington, D. C.—Although the budget, defense and farm policy are monopolizing Washington headlines, Congress is paying more than casual attention to the health and social security fields. In these, as in other legislative areas, it has for its guidance a specific program, laid down by President Eisenhower in his various messages during the first few weeks of the session. The question now is whether this closely-divided Congress will have the time and/or the inclination to follow through on everything the Administration wants.

Before Congress settled down to its task, the President met with a group of American Medical Association leaders, who discussed with him the Association's position on several important pieces of legislation. Present at the White House meeting, in addition to Mr. Eisenhower and Sherman Adams, Assistant to the President, were AMA President Edward J. McCormick, Trustees' Chairman Dwight H. Murray, President-Elect Walter B. Martin, and Washington Office Director Frank E. Wilson.

Congress got into the health and welfare field with no waste of time. Within five days after Congress reconvened the House Interstate and Foreign Commerce Committee, under the chairmanship of Rep. Charles Wolverton (R., N. J.), began an exhaustive series of hearings on voluntary health insurance, further evidence that the Administration is determined to get some action in this direction.

Chairman Wolverton as long as four years ago was interested in legislation to help pre-paid insurance programs extend their coverage and increase their benefits. In 1950 he incorporated his ideas in a bill, but it was not acted upon by the committee and was not revived until this year. Now the atmosphere is much more favorable for Mr. Wolverton's proposal. Not only is he chairman of the committee and his party in control of Congress, but his ideas have strong support from the Administration.

Basically the Wolverton idea is an FDIC for voluntary health insurance. In about the same way the Federal Deposit Insurance Corporation insures bank deposits up to a certain limit, the Wolverton program would insure (or re-insure) various types of hospital, surgical, and medical insurance programs. The proposal is for the federal government to set up a national health insurance underwriting corporation. To keep the corporation going, the member plans would contribute a certain percentage of their gross receipts, possibly 2%.

With the national corporation underwriting unusual risks, the individual programs could offer catastrophic or "complete" coverage. By scaling individual premiums to the family income, the member plans also could offer protection to families with very low incomes. The national corporation would pay possibly two-thirds of each subscriber's claim in excess of, say, \$500 or \$1,000 in any one year.

Another piece of legislation, receiving favorable attention, also would help families with their medical expenses—a proposed liberalization of income tax deductions allowed for medical expenses. Under present law, only that part of medical expense exceeding 5% of taxable income may be deducted. The pending legislation would drop this to probably 3 per cent, and raise or eliminate the maximum limit. In past years scores of bills pointed in this direction have been introduced. If this is incorporated in the general tax overhaul legislation, it is believed to have a good chance of enactment.

Secretary Hobby's Department of Health, Education and Welfare is firmly behind a proposal to have the federal government show more leadership in vocational rehabilitation of the handicapped. At this writing it is too early for any good indication as to whether physicians will be brought under social security. The Administration's bill would blanket in most self-employed groups, including dentists, attorneys, architects and farmers, in addition to physicians. Rep. Carl Curtis (R., Neb.), chairman of the subcommittee which investigated social security, apparently feels the same way. However, a substantial number of the members

of the House Ways and Means Committee, which must pass on the bill, are known to feel that compulsion should not be used on groups that do not want Old Age and Survivors Insurance.

From all indications available during the first few weeks of Congress, a showdown fight may be unavoidable on medical care for military dependents. Defense Department, with support from the President, wants dependent care extended and made uniform among the three services, with military physicians carrying as much of the responsibility as they can. Under the Defense Department plan, dependents who could not be taken care of at military installations would be allowed to obtain their care from private sources, with the government paying almost all of the cost.

The American Medical Association agrees with the Defense Department that all dependents should receive medical benefits as nearly uniform as possible. However, AMA contends that wherever possible dependents should use private physicians and private hospitals, and that the military personnel and facilities should be employed only where civilian facilities are inadequate.

EARLY REMINDER
Med-Chi Faculty Ball

APRIL 26, 1954

THE ALCAZAR



Dance 9 p.m.—1 a.m.

Variety Show 10 p.m.—“MEDICANA”

Coronation of Baltimore's “*Outstanding Student Nurse*”

Raffle of Mink Stole!

MARK THESE DATES ON YOUR CALENDAR

PLAN TO ATTEND

The Annual Meeting
of the Medical and Chirurgical Faculty

➡ April 26, 27 and 28, 1954 ⬅

Business Meetings, Monday, April 26, 1954 and Wednesday, April 28, 1954.

Scientific Sessions, Tuesday, April 27, 1954 and Wednesday, April 28, 1954.
Day and Evening Meetings. Also Round Table Luncheon and Buffet Supper.

The first article in the March Journal will contain a preview of the Annual Meeting, and the usual program will be mailed in April about two weeks prior to the Meeting.